Doctoral Portfolio In Counselling Psychology

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A portfolio submitted to The University of Wolverhampton for the Practitioner Doctorate:

Counselling Psychology Award: D.Couns.Psych

January 2016

DECLARATION

This research dossier has not been previously submitted in any form to this University or to any other institute of learning for the intention of assessment, publication or additional purpose (unless specifically specified). With the omission of acknowledgments and references presented in this portfolio, I confirm that the contents of this work is a product of my own efforts and nobody else, except the expected input from my research supervisors Dr Wendy Nicholls and Dr Abigail Taiwo.

Signature: .....

Date: .....

ACKNOWLEDGEMENT

I would like to thank my supervisor, Dr Wendy Nicholls, for her consistent availability and support. I appreciate her undeniable encouragement towards reaching for the highest standards. Additionally I would like to extend some gratitude to Dr Abigail Taiwo for her input and assistance.

Secondly, I would like to thank my placement supervisor Dr Shirley Timpson for being my saving grace at a critical time. I do not believe I would be where I am without your investment. You have been an inspiration and I can only hope to embody the qualities you do as a professional.

My third acknowledgment extends to the peers within my cohort. Their mutual panic has provided relief alongside their kindness and encouragement that I can succeed has offered reassurance.

Finally, I would like to thank my mother, fiancé and my daughter. Chris, you have been my rock and supported me through this extremely challenging experience. Mia, you have been my driving force to succeed and meet deadlines and I cannot thank the pair of you enough for keeping me sain and smiling

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PREFACE

This thesis is presented in four sections comprising of an academic dossier, therapeutic practice dossier, research dossier and a critical reflection. Each section provides insight into the multiple areas of training the author has completed as part of their journey toward becoming a recognised professional in the area of counselling psychology.

The academic dossier includes two pieces of work completed by the author during the training that demonstrate her abilities as a professional through the use of case examples. The first relates to the author's abilities to recognise and uphold the ethical guidelines required for maintaining good practice. The second focuses on two differing approaches to therapy and what that looks like using a specific case example.

The therapeutic practice dossier provide in depth understanding into how the author has developed as a professional including the areas where her therapeutic practice took place. The first piece is a reflection of the author's professional development and growth as a counselling psychologist throughout the doctoral training, which includes the integration of both theory and practice, the use of supervision and personal therapy. The second piece is a portfolio of evidence demonstrating the author's therapeutic practice journey.

The research dossier comprises of four chapters following an abstract. Chapter one focuses on a literature review based around attachment within the therapeutic environment. It encompasses all the elements that contribute towards the research questions including the impact of both client and therapist attachment styles on therapeutic outcome and relationship. Throughout the review,

studies are critiqued and their significance in relation to the current research study are discussed. The review finishes with the hypothesis and research questions for the current study.

Subsequent to the literature review is the research paper, which assessed the interaction between self-reported attachment styles on the therapeutic relationship and therapeutic outcome. The main hypothesis of the study was that a specific attachment style combination (client attachment style and therapist attachment style) would provide better therapeutic outcomes for the client and a better therapeutic relationship would be established. In addition to the hypothesis, research questions focused on identifying which style of attachment provided better outcomes upon interaction. There were 38 client and therapist combinations recruited from private therapeutic services. Clients completed outcome measures at session one and session six of therapy. Both client and therapist completed a self-report attachment measure at session one of therapy and a therapeutic alliance at session six of therapy.

The third chapter details the results for the study. Client and therapist attachment combinations were not predictive of the therapeutic relationship or therapeutic outcomes. However, secure therapists significantly correlated with the therapeutic relationship or therapeutic outcomes. In addition, client perceived alliance was significantly correlated with a reduction in symptoms of depression.

The fourth chapter discusses the results in greater depth, focusing on limitations and how the results contribute to existing and future research.

Finally, the critical review is the fifth chapter and provides a detailed evaluation of the research process. The rationale for the literature review is initially outlined, followed by considerations surrounding the methodology for the research. This section concludes with implications for therapeutic practice and clinical implications followed by suggestions for future research within the research area.

Academic Dossier

Therapeutic Issues & Ethics PS5001: Self-Disclosure Issues and Dual Relationships as Ethical Dilemmas In The Therapeutic Environment

In line with client confidentiality, all names and identifying information have been changed (BPS, 2009).

Professions use ethical principles (Beauchamp & Childress, 1983) to construct ethical frameworks to guide the conduct of their members. Psychologists are committed to following the British Psychological Society's (BPS) code of ethics and conduct (2009) and counselling psychologists, in particular adhere to the BPS Division of Counselling Psychology (DCoP) professional practice guidelines (2006). As a health professional it is necessary that we respect the standards of conduct, performance and ethics of The Health & Care Professions Council (HCPC). These professional bodies among others all provide guidelines on ethical conduct and illustrate the responsibilities of a practitioner (Bond, 2000). However, guidelines can be described as general rules, principles, or advice (Banyard & Flanagan, 2006) and therefore, practitioners must use their understanding of these guidelines in combination with their own moral codes (behaviour driven by knowledge of what is right or wrong) (Reynolds & Ceranic, 2007) standards and principles in order to do what is paramount for the client. Orlans (2007) highlights that there may be multiple ways to proceed in a given situation, emphasising the route for one client may not be beneficial for another.

This paper presents a case example from a trainee counselling psychologist's clinical placement experience. The case example provides two very distinct ethical dilemmas that have had an impact on the development of the clinician as a health professional and the therapeutic work carried out. These are self-disclosure and dual relationships and occur within many therapeutic environments. Ethical principles that conflict with the dilemmas from several professional bodies will be identified. It is important to consider the impact that theory has on the decisions made by the practitioner when faced with ethical quandaries (BPS, 2009; HCPC, 2010) therefore, key findings amongst research will also be discussed. Several terminologies ('professional', 'clinician' and 'practitioner') are referred to throughout the text to describe the counselling psychologist.

The HCPC (2010) recognises the importance of good practice guidelines set by individual societies for their members which facilitate practitioners in meeting the standards set by them ensuring they practise 'lawfully, safely and effectively' (p. 3). The BPS ethical principles require their members to adhere to four standards, which are respect, competence, responsibility and integrity. Elements within all of these principles are susceptible to violation as a result of self-disclosure and dual relationships, all of which will be discussed or referred to.

Case 1

The therapist was a trainee counselling psychologist on placement in a secondary care, community mental health team. The therapist chose her own clients from the waiting list based on their suitability for a trainee and their presenting problem. The therapist chose Laura M from the waiting list, as she was suitable for Cognitive behavioural therapy (a requirement of training).

Ms M was a 32-year-old female, attending therapy for the treatment of unresolved trauma resulting in anxiety and depression.

Self-disclosure was used to normalise situations and reduce any power barriers, consequently strengthening the relationship, e.g. whilst normalising negative automatic thoughts (NAT's), the therapist disclosed how failing an assignment resulted in thoughts that they could not do it and were not good enough. This was intended to reassure the client that they are common thoughts and everybody has NAT's regardless of their mental health state. In addition this also helps the client to see the therapist as human and equal therefore reducing the power barrier.

The therapeutic relationship was established relatively early in treatment and felt very natural as though therapy had been in progress for several months. Ms M reminded the therapist of a 'big sister', which provided a warm atmosphere during the sessions. In contrast, the therapist felt her role symbolised that of a 'big sister' guiding the client to a healthier place. The therapist felt Ms M was an individual she could be friends with under different circumstances away from therapy. Being consciously aware of these thoughts throughout treatment, the therapist felt they added interferences during sessions consisting predominantly of self-disclosure. This comprised of self-interrogation of whether or not something should or should not be shared with Ms M and if the information would be useful to her or information that would be shared between friends over coffee and facilitated the needs of the therapist. For example, sharing opinions of recent movie viewings when commuting to and from the therapy room. The therapist felt that self-disclosing this type of information was not therapeutically beneficial and given that they felt a connection with the client, may lead to the development of a dual relationship. Relationships between

friends are generated through the exchange of information. However, within the therapeutic environment, ethical principles and codes of conduct prevent this from occurring providing the professional adheres to them. This is to ensure the best interests of the client and practitioner are maintained (BPS, 2009).

In the face of this dilemma, the therapist completed treatment with Ms M following 24 sessions without disclosing any personal information that was not therapeutically beneficial to Ms M and abstained from developing a secondary relationship. This was achieved by the therapist asking themselves if what they were about to disclose would be useless to the client, would it harm the client and if it benefitted the therapist. If they could answer no to all of the above the therapist felt confident that they had adhered to the standards within the ethical principles of respect, integrity, competence and responsibility. Failure to adhere to these standards results in a breach of ethical conduct, subsequently rupturing therapeutic boundaries and affecting client vulnerability. Specific standards are explained in greater depth throughout the remainder of this paper.

Self-disclosure

Self-disclosure is a method of communication through which one reveals themselves to another. It encompasses everything one wishes to share with another about themselves and may include thoughts, feelings, aspirations, failures, accomplishments, anxieties and dreams, along with likes and dislikes (Ignatius & Kokkonen, 2007). It is used within the therapeutic environment to enhance the relationship between the therapist and the client. This may involve voluntary disclosure from the therapist or as a response to a client's question.

Self-disclosure poses a number of concerns. The most common is the belief that self-disclosure is used for the therapist's benefit rather than therapeutic purposes or for the benefit of the client. Therefore it is important that the therapist's objective is motivated toward client well-being and not toward the therapist's needs or desires (Barnett, 1998; Mallow, 1998; Bridges, 2001; Zur, 2007). "Harry Stack Sullivan . . . once observed that psychotherapy is a unique profession in that it requires therapists to set aside their own needs in the service of addressing the patient's needs. He further noted that this demand is an extraordinary challenge for most people… because the needs of the psychotherapist often get in the way of the therapy, the established guidelines, often referred to as boundaries, are designed to minimise the opportunity for therapists to use their patients for their own gratification" (Gabbard, 1994, p. 283). The above emphasises the requirement of work/life balance for practitioners to ensure these boundaries are not violated as this may result in the client feeling exploited (Zur, 2007).

Self-disclosure that is intentional and deliberate is made under the general moral and ethical principles described by the BACP (British Association of Counselling and Psychotherapy) as Beneficence 'A commitment to promoting the client's well-being' (BACP, 2013, p. 2) and Non-maleficence 'A commitment to avoiding harm to the client' (BACP, 2013, p. 2). Furthermore, the therapist's self-disclosure should be moderate and pose no burden on the client, nor should the client switch roles with the therapist. It is a commonality amongst scholars and ethicists that professionals should not share their desires with clients (Pope, Tabachnick, & Keith-Spiegel, 1987; Gabbard, 1989; Stricker & Fisher, 1990; Fisher, 2004). The BPS makes no reference to self-disclosure directly but several standards can be applied to its ethicality e.g. the "standard of

general respect" (BPS, 2009, p. 11) states that practitioners should avoid unjust practice. Appraising the above ethical guidelines leaves one questioning what is considered harmful, burdensome or unjust? What may be to one client may not be to another and what one professional considers harmful, burdensome or unjust another may not. Thus causing speculation into the validity of such ethical codes.

In addition, to ethical conduct being compromised, it has been evidenced that, self-disclosure can pose other risks. The most detrimental being, undoing the effects of therapy or reversing the responsibilities of therapist and client. Clinicians must be mindful when choosing what personal information to disclose and when in therapy to do it. For example, a client in crisis is unlikely to gain solace from self-disclosures. If client-therapist roles are reversed at any stage and the client finds they are supporting the therapist, self-disclosure becomes an obstruction in the therapeutic process. Moreover, excessive self-disclosure from the therapist may result in the client viewing the professional as undependable and weak as opposed to a support system (Sturges, 2012). It is important to recognise that self disclose also poses risks for practitioners (BPS, 2009). E.g. revealing where you spend your spare time generates the risk of bumping into clients leading to further ethical implications. Those who see clients at home privately is self-disclosure in itself (Zur, 2007).

In the face of conflicting research, self-disclosure is regularly used in therapy and is recommended by some modalities. The American Psychological Association refers to this act as 'promising and probably effective' (Ziv-Beiman, 2013, p. 63). Behavioural, cognitive and cognitive-behavioural therapies have highlighted the significance of modelling, reinforcement

and normalising in therapy, viewing self-disclosure as a successful tool that enriches these techniques (Freeman, Fleming, & Pretzer 1990; Goldfried, Burckell & Eubanks-Carter, 2003). Lazarus (1994), a founder of behavioural therapy, believes it is important for therapists to answer clients' appropriate questions and emphasises how disruptive clinical processes of returning client enquiries with questions can be (e.g., 'Why is this important for you to know?') as opposed to responding to the questions. Several authors report how valuable self-disclosure in Rational-Emotive Therapy (RET) can be. Multiple researchers have found that clinicians who used self-disclosure and personal examples to model the rational-emotive process was an effective method in assuring clients of the efficacy of the approach (Dryden, 1990; Tantillo, 2004). However, Epstein (1994) argues that non-self disclosure is still disclosure in that it provides the client to form such opinions of the therapist that they are distant or callous.

Self-disclosure may be considered ethical providing the client is not maltreated (Sturges, 2012). In the case example, the therapist believed that their disclosure was of benefit to the client, however this was only upon their reflection, consequently resulting in the development of a mental checklist in order to ensure ethical adherence. This is not to say that slips of the tongue are absent in the midst of therapeutic discussion. Professionals are advised to use self-disclosure sparingly and to remain client focused following its usage to ensure best practice (Ziv-Beiman, 2013). The BPS (2009) standard 3.1 (i) guides practitioners to "avoid harming clients but take into account that the interests of different client's may conflict" (p. 18). In relation to self-disclosure, it may be useful with some clients and detrimental to others. E.g. some clients may feel understood and that they are not alone whilst others may feel their experience is considered

'normal' yet to them it was significant. As a result, clinicians should consider both benefit and risk and alternative routes before acting (BPS, 2009).

There are a variety of perspectives on the ethical implications of self-disclosure. Several researchers believe therapist self-disclosure to be exploitative (Pope, 1990; Zur, 2000; Peterson, 2002; Hanson, 2005) yet in contrast some emphasise beneficial reasons for its use (Watkins, 1990; Ignatius & Kokkonen, 2007; Paine, Veach, MacFarlane, Thomas, Ahrens & LeRoy, 2010; Sturges, 2012; Ziv-Beiman, 2013). The ethicality of self-disclosure will probably depend on the rationale for disclosing, the content and circumstances around the disclosure (Gutheil & Gabbard, 1993; 1998). Studies report clients obtain both positive and negative experiences from the self-disclosures of their therapist (Farber, Berano, & Capobianco, 2004). Due to the uncertainty and difficulty surrounding this ethical issue, therapists must consider multiple ethical principles when using interventions that involve self-disclosure (Peterson, 2002) as being negligent can lead to professional investigations that may ultimately disrespect the profession (BPS, 2009).

Dual Relationships

Dual relationships were recorded as the second most frequent ethical dilemma referred to by 679 psychologists (Pope & Vasquez, 1998). They occur when professionals partake simultaneously or consecutively in more than one functional role (Kitchener, 1986; Zur, 2013). A dual relationship exists when there is an additional role relationship present to the professional one, to which there are several e.g. friend, family member, student or business associate (Carroll, Schneider & Wesley, 1985; Faulkner & Faulkner, 1997; Zur, 2007).

Role theory can be used to explain issues with dual relationships. Social roles include in-built expectations about how individuals in specific roles should behave as well as rights and responsibilities that relate to that role (Kitchener, 1988). This can be harmful and confusing for both the client and therapist (Zur, 2007) as conflicts between roles can occur when the expectations of one role require behaviours that are discordant with the expectations of another role (Kitchener, 1988).

In the case example the therapist feels an attachment to the client. Some professionals establish such a significant bond with clients that they participate in friendships with them. Occasionally these friendships meet the subconscious emotional needs of the practitioner (Moursund, 1985); they may be encountering a personal crisis, and the friendship with this client may provide comfort and valuable support (Gottlieb, 1995). Friendships between practitioners and clients can be just as harmful as sexual relationships. The Friendship between the professional and the client may inhibit the ability of the practitioner to provide a professional and impartial service to the client should the client wish to address new concerns in a therapeutic manner. If the client was to start over with a new professional it can have financial, emotional and psychological implications. Practitioners risk harming clients when the boundaries are confused by friendships, irrespective of whether their intentions were decent (Gottlieb, 1995). E.g. client's who are vulnerable can feel exploited if boundaries are unclear (Lazarus & Zur, 2002). This emphasises the importance of the therapeutic contract (BACP, 2013).

Therapeutic relationships and friendships have been compared by researchers (Reisman &

Yamokski, 1974; Corrigan, 1978; Reisman, 1986). They found some similar characteristics (Aukett, Ritchie & Mill, 1988; Berzoff, 1989) between them that include trust, understanding and respect (Argyle & Henderson, 1984; Wiseman, 1986; Schultz, 1991). They also report numerous differences. For example, therapeutic relationships impose a context of treatment where interactions are controlled and time limited (Arnold & Boggs, 1989); the union that is present is formal, where the therapist is required to adhere to professional codes of ethics and standards of conduct (Reisman, 1986); the therapist holds a position of power, and the interaction of confidences is a one-way process, the relationship is unequal (Wolman, 1984). In contrast, friendships are voluntary and possess an informal connection between two persons who share confidences and pursue each other's company (Allan, 1989). Friendships are sociable (Allan, 1989), equal and remain because interactions are rewarding for both parties (Bell, 1981).

Literature identifies the fundamental difficulties encountered by therapists who endeavour to balance multiple relationships (Martin, 1983; Steere, 1984; Moursund, 1985). When a therapist-client relationship becomes tangled, it is difficult to identify where the therapeutic relationship ends and friendship begins. Failing to identify the distinction between them and setting adequate boundaries, the client and therapist are in danger of complications that may affect therapeutic process. For the client, these difficulties might include emotionally depending on the therapist, resulting in the abandonment of constructing supportive relationships with others (Sylvester, 1985); and, preferential treatment may lead to confusion and feelings of betrayal when expectations are not met (Cherniss, 1980). For the therapist, difficulties can include stress, which is likely to lead to professional burnout and affect additional clients (Pines, Aronson & Kafry, 1981); and, allegations of misconduct (Cherniss, 1980). However, psychodynamic theorists may

argue that these complications could strengthen the therapeutic relationship following discussion (Jacobs, 2004).

Avoiding dual relationships is an aspiration that mental health professionals strive to achieve but one that is difficult to avoid (Kieth-Spiegel & Koocher, 1985; Haas & Malouf, 1989; Adleman & Barrett, 1990). Pearson & Piazza (1997) reported that 23% of ethical complaints were as a result of dual relationships. The BPS code of ethics and conduct (2009) refers to the use of supervision to support the clinician in making ethical judgements. Supervision provides a space for them to discuss their current client work including any difficulties and also enables reflection of interventions to facilitate personal and professional development. Not only does supervision ensure client needs are being met, it ensures ethical standards are being maintained (Bernard & Goodyear, 1992) emphasising the importance of supervision to assist the practitioner in preventing the development of dual relationships (Zur, 2013). The therapist's desire to have a relationship with the client outside the therapy room and feeling a role of 'big sister' in the case example may indicate transference within the relationship, providing an example of the material this practitioner took to supervision.

Limited findings provide support for engaging in dual relationships. The research that does, refers to the ability to manage them under certain circumstances when they appear unavoidable i.e. in small communities (Gottlieb, 1995). The majority of the research around dual relationships discusses the prevalence of them or the ethics surrounding them. There exists a major gap within research that explores the rationale for practitioners wanting to engage in friendships with their clients or feeling a connection between them. It is possible that this research is non-existent as a

result of dual relationships being prohibited in mental health professions and clearly stipulated in the codes of conduct. The British Psychological society (BPS, 2009) states under conduct code 4.2 (ii) that professionals should "Refrain from abusing professional relationships in order to advance their sexual, personal, financial, or other interests" (p. 22) and that they should "Remain aware of the problems that may result from dual or multiple relationships" (p. 22). In addition, standard 4.3 (i) asserts professionals should "refrain from engaging in any form of sexual or romantic relationship with persons to whom they are providing professional services" (BPS, 2009, p22). These codes guide psychologists to avoid multiple relationships and to be cautious should they be unavoidable. The development of dual relationships with clients is likely to lead to professional impairment where client well-being is compromised due to the therapist having a view on the client situation from an additional role perspective (BPS, 2009).

It is worth considering existing theories to explore the connection between therapist and client, for example, attachment theory. Much of the research examines the client's attachment to the therapist and the therapist acting as a secure base for the client to explore their difficulties (Bowlby, 2005; Lyon, Gelso, Fischer & Silva, 2007). However, the attachment style of the therapist is rarely considered within the therapeutic environment and it is likely to have an effect on the therapeutic outcome. In addition, it poses a question around different attachment styles of therapist and client having higher compatibility rates than others e.g. insecure client vs. secure therapist may be more compatible than insecure client vs. anxious therapist. This may provide an explanation for the connection felt by the therapist in the case example presented yet this area requires further investigation. If research were to find compatibility among attachment styles of client and therapist, it may require further examination of ethical principles.

Considerations for Counselling Psychologists

It has been revealed that there resides a conflict amongst findings around the use of self-disclosure. However, what remains a commonality is the encouragement to uphold client well-being. Providing the client's best interests are at the forefront of the decision to self-disclose, it is deemed an acceptable therapeutic intervention.

There is little if any research that looks at the link between self-disclosure and dual relationships. As discussed, self-disclosure is used to share information and build relationships. It is not irrational to suggest that continuous use of inappropriate self-disclosure would inevitably lead to a dual relationship with a client. Findings in this area may strengthen existing research around the implications of self-disclosure and the link that may be identified would stress the importance of avoiding dual relationships in addition to further support for how they can be managed.

Although dual relationships are referred to within the HCPC (2010) and the BPS (2009), they appear as a statement within an ethical principle. The APA (American Psychological Association) (2010) presents a detailed definition of dual relationships and what a psychologist should do if presented with the dilemma. Thus providing practitioners with additional guidance. This presents an area of improvement for British ethical frameworks to consider.

Conclusion

The practitioner in the case presented displays evidence of responding ethically to therapeutic dilemmas. They were aware that their thoughts toward the client were against the ethical framework for counselling psychologists, therefore demonstrating their "competence" (BPS, 2009, p. 15) in attaining ethical decisions and the ability "to recognise appropriate boundaries" (HCPC, 2010, p. 6). However, this was only recognised through reflection and supervision around fears the therapist had that their actions may have been deemed unethical.

Every encounter a psychologist has with a client will present new ethical challenges and each one will be unique. Analysis of ethical principles reveals the pressure professionals must feel in adhering to the codes. One must contemplate an ethical route for each client requiring consideration of a wide range of factors during each contact. This places emphasis on the need for supervision as it is feasible to understand that mistakes can be made. It would be unattainable for societies to provide a 'how to' guide for every situation one comes across in practice. In asking practitioners to use their own moral judgement along with the ethical framework, it ensures the overall safety of the client and the professional in any given situation providing they conduct themselves in the manner stipulated (HCPC, 2010). Therapists must be thorough when contracting and establishing boundaries from the first session (HCPC, 2010) making the client aware of what their professional relationship consists of. The use of supervision ensures the maintenance of ethical protocol providing a safe therapeutic environment for both parties.

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Working with Couples & Families PS5009: Compare And Contrast Two Different Theoretical Approaches To Couples Therapy.

Introduction

This paper endeavors to evaluate the similarities and differences between two theoretical approaches for working with couples. The aim is to compare and contrast Emotionally Focused Therapy for couples (EFT-C) and Cognitive Behavioural Couples Therapy (CBCT) and provide insight into how they may formulate in a clinical setting with the use of a case study of a couple accessing couples therapy (Appendix 1) that was obtained within a lecture. The case study has been anonymised in line with the BPS code of ethics and conduct (BPS, 2009). A detailed account of these therapies and how they might be applied is beyond capacity for this paper. However, it will hopefully afford an overview and further understanding into how counselling psychologists might possibly practice with couples.

Overview of EFT-C & CBCT

Johnson & Greenberg's (1985) Emotionally Focused Therapy (EFT-C) is a brief (8-20) sessions), systematic approach to couples therapy. EFT-C combines humanistic, experiential and family systems methods to therapy and is firmly embedded in attachment theory. EFT-C sees the therapist persistently engaged in three tasks: continually maintaining a safe collaborative relationship with both partners, concentrating on and developing emotional responses that influence interactions between the couple, and relating these responses repeatedly to the interactional patterns that resulted in the couple attending therapy. Finanlly the therapist helps to restructure these patterns toward accessibility and responsiveness (Johnson, 2004)

EFT-C comprises of three stages with a total of nine steps (Appendix 2). The first four steps of stage one include the assessment and reducing cycles of interaction that cause conflict. Stage two (steps 5-7) emphasises change in interactional positions and new ways of connecting transpire. At stage three (steps 8-9) of therapy the changes from stage two are integrated and consolidated (Carson & Casado-Kehoe, 2012). Within these stages the role of attachment is integrated and particularly important (Reid & Woolley, 2006). Bowlby asserts that the majority of difficult behaviour is due to threat (past or present) to secure attachment. Uncertainty and fear trigger the needs and behaviours of the attachment system (a need to maintain/achieve proximity to an attachment figure). When a partner experiences hurt that is strong enough to instigate them to question their relationship, EFT-C refers to this as an attachment injury (Johnson, Makinen, & Millikin, 2001). Attachment injuries are typically "violations of human connection" (Herman, 1992, p. 54) such as abandonment or betrayal. They can be described as relational traumas (Reid & Woolley, 2006) that are activated when there is risk in the area of vulnerability, and subsequently this prevents couples from re-engaging. In order for a relationship to progress positively towards restoration, EFT-C considers it a necessity to address attachment injuries of both partners (Reid & Woolley, 2006).

On the other hand, CBCT is grounded within CBT methods and asserts that individuals consciously experience thoughts between an external situation and a specific emotional response. Implying that it is not the event that elicits the emotion but rather the meaning that one assigns to them (Beck, Rush, Shaw, & Emery, 1979). According to Ellis (1977), marital dysfunction occurs when a partner holds beliefs about their relationship that are unrealistic and research has revealed that once one or both partners is unhappy they tend to focus on any negative behavior expressed by the other partner (Jacobson, Waldron, & Moore, 1980), reciprocating negative behavior with

negative behavior (Gottman, 1994, 1979). Ellis (1977) further purported that feelings of distress within the relationship are the result of a partner's views of one another's actions and life stressors as opposed to their partner's actual actions.

The cognitions of an individual are considered by this theory to be comprised of both *'Automatic thoughts'* and *'schemas'*. Beck et al. (1979) identified automatic thoughts to be impulsive ideas or beliefs that occur continuously minute-by-minute. These thoughts can be positive and negative. However, it is the negative thoughts that cause conflict within the relationship. The basic core beliefs of oneself, others and the world are refereed to as schemas and are often established in childhood (Datillo, Epstein, & Baucom, 1998). The purpose of a CBCT therapist is to recognise the connotations a couple ascribes to their experiences. In order to achieve this, the therapist must collaboratively support the couple in identifying erroneous beliefs using an assortment of interventions to modify errors and encourage them to assess the unrealistic properties of their belief system (Beck, 1976). The repeated exchange of negative behaviour between partners is correlated with relationship discord (Biglon, Levin & Hops, 1990). A significant element within CBCT is the behavioural aspect, which examines the communication, problem solving and the pattern and frequency of negative behaviours (Datillo et al., 1998). To address this dysfunctional component of the relationship behavioural experiments (Appendix 3) are conducted, which happen to be defined as one of the most effective methods for influencing change (Bennett-Levy, Butler, Fennell, Hackmann, Mueller, & Westbrook 2004).

A significant difference between models is that EFT-C places emphasis in emotion as the element of distress (Gurman & Jacobson, 2008), whereas CBCT considers emotions to be

barriers and that it is cognitions that require altering in addition to behaviour in order to facilitate permanent change (Gurman & Jacobson, 2008). Within CBCT emotion is used in a coherent theoretical model and regarded as one stage in a process of problem solving (Epstein & Baucom, 2002). EFT-C is motivated by ones need to maintain proximity to attachment figures (Gurman & Jacobson, 2008) and emotions such as anger are considered to be the response when attachment security is threatened (Johnson, 2009; Gurman & Jacobson, 2008). CBCT regards such emotions as negative that are experienced as a result of one believing in biased representations and evaluations of self (Baucom, et al. 2008). Furthermore, interventions within EFT-C are tailored depending on the style of attachment fostered by each individual in the unit. Whereas CBCT is tailored toward the symptoms of the mental health difficulty that presents itself. For example, a woman who fears (without reason) that her partner will abandon her might address this anxiety with a thought record to alter her maladaptive thinking patterns Gurman & Jacobson, 2008).

Perspectives of Relationship Health & Distress

An important objective among all couples therapy is to facilitate couples in achieving a healthy functioning relationship. Whether this is as a unit or as individuals. Having a model of a healthy relationship is fundamental for the therapist as this enables goals and key processes to be determined (Gurman & Jacobson, 2008).

CBCT therapists consider healthy relationships between couples to include the couple as individuals, as a unit and to include the impact their environment has on the relationship (Epstein & Baucom, 2002; Baucom, Epstein, & LaTaillade, 2002). Baucom, Epstein, & Sullivan, (2004) define a “healthy relationship” as contributing to the wellbeing, growth and needs of both companions, where they can operate together as a unit (Epstein & Baucom, 2002) and adapt

appropriately to changes in their environment. This includes, each party providing support during times of distress (Pasch, Bradbury, & Sullivan, 1997; Cutrona, Suhr, & MacFarlane, 1990) by assisting with domestic tasks or providing comfort (e.g., attentively listening to their partner). Furthermore, partners have the ability to communicate effectively, resolve difficulties efficiently and adapt to changes that occur such as pregnancy (normative), career moves and loss of loved ones (non-normative) (Epstein & Baucom, 2002). As these normative and non-normative demands occur in the couple's life, it is how they respond that determines growth or deterioration within their relationship. Couple and individual vulnerabilities as well as environmental resources influence this (Epstein & Baucom, 2002). Therefore a healthy relationship is considered to be one where the couple can adapt accordingly to changes in demands that result in partners needs (relational and individual) to be met nonetheless.

CBCT among other theories involving therapy with couples have been considered to be deficient in incorporating a "theory of love and relatedness" (Gurman & Jacobson, 2008, p. 112; Johnson & Lebow, 2000; Roberts, 1992). Attachment theory fulfills this requirement thus a healthy relationship expressed by the EFT-C theory is one with a secure attachment bond. A secure bond is depicted as both partners being emotionally available and responsive which, in turn provides a 'safe haven', enhancing partners' ability to solve problems, settle differences, communicate effectively and most importantly regulate ones emotions. Research focusing on adult attachment has revealed that secure relationships are correlated with increased levels of trust, intimacy and satisfaction (Johnson & Whiffen, 1999; Cassidy & Shaver, 1999). Seeking proximity to an attachment figure is an innate method of regulating emotions from *"cradle to the grave"* (Bowlby, 1969/1982, p. 208). Securely attached individuals believe distress within

relationships is repairable, as they have probably had prior experience of this by turning to others and receiving support responsively. As a result ones ability to manage stress facilitates resilience in future situations. Those with a less secure attachment are vulnerable in environments where stress is elevated and struggle to respond and engage emotionally with one another. Attachment theory specifies that situations that occur where a partner requires comfort and support, and they believe their partner is unresponsive (attachment security is threatened), are critical in terms of whether they consider their relationship to be fulfilling and/or distressing (Johnson, 2008).

It is worth noting from the descriptions of CBCT and EFT-C that CBCT theorists appear to consider attachment to be an important factor. However, there is no reference to it in such terms. For example CBCT therapists describe a healthy relationship to consist of similar features of EFT-C theorists, which in EFT-C refers to the ways in which a secure relationship functions (Gurman & Jacobson, 2008). It could be argued that CBCT theorists appear to value features of a secure relationship but place no emphasis on the fact that it is attachment and refrain from delving into the complexities of attachment theory. Similarly, schemas within CBCT that are developed from childhood and are ones core patterns of behaviour might be considered to represent attachment styles within EFT-C, which too are developed from childhood as a result of interactions with significant others (Johnson, 2008). Both impact the way individuals behave and affect the beliefs about oneself, others and the world. Yet the contrast between theories falls in how change is implemented (Gurman & Jacobson, 2008). In EFT-C ‘change occurs through new emotional experience in the present context of attachment-salient interactions’ (Gurman & Jacobson, 2008, p 115) whereas change within CBCT occurs through the testing and modification of existing maladaptive thoughts and behaviours (Gurman & Jacobson, 2008)

Formulation of Case Study

Formulation is an integral feature in counselling psychology practice (Division of Counselling Psychology, 2012) and endeavours to hypothesise a personal account of the roots, precipitants and maintaining factors of an individual's interpersonal, psychological and behavioural difficulties (Eells, 1997). Thus placing much emphasis on counselling Psychologists using EFT-C and CBCT to incorporate formulation into their practice as an opportunity to comprehend and reflect on a couple's difficulties in addition to the application of psychological theory (Johnstone & Dallos, 2006). This is exhibited by employing EFT-C and CBCT methods to the case example.

EFT-C considers the root of clinical disorders to be emotional disorders (Johnson & Greenman, 2006). Formulation within an EFT-C model has an organised structure and a map to guide therapists in addressing the couple's emotional difficulties (Johnson, 2007). Focus is placed on the stories told by partners and how they feel as a result (Gurman & Jacobson, 2008). In concentrating on this interaction between the narrative and emotional processing, inline with specific consideration being played to the underlying painful emotion of the presenting problem, therapists are able to decide moment-by-moment how to proceed in therapy (Goldman & Greenberg, 2014). Consequently, partner's maladaptive emotions are adjusted, creating increased flexibility surrounding the meanings partners place in feelings and events (Goldman & Greenberg, 2014).

EFT-C therapists avoid instigation of prominent target areas. Instead, they work collaboratively

to assemble the most distressing and problematic experiences that surface progressively throughout therapy (Palmer & Johnson, 2002). From the case example, Rabina exhibits frustration toward James' excessive working hours. This displays Rabina's need to obtain proximity to her romantic attachment figure (James). James views her expression of this frustration as 'nagging' behaviour. The therapist may consider directing James's attention (through intervention; Appendix 5) toward understanding that Rabina's actions are due to the fact that she enjoys his company, would like to spend more time with him and finds his hours difficult because they prevent this from occurring.

Furthermore, Rabina's feelings of rejection and lack of confidence as a result of James withdrawal from sex, may leave Rabina feeling vulnerable which consequently activates Rabina's attachment injury from her previously emotionally abusive partner. Rabina would need to work through this attachment injury first before work as a unit could continue. James's attention would be directed toward understanding into the cause of Rabina's actions. Following this, Rabina's attention would be directed toward understanding that her behaviour results in James feeling pressured leading him to possibly feel like a failure for his inability to perform. This leads to further withdrawal as a result of his early attachment experiences that emotions are felt not heard.

Formulation from a CBCT perspective considers the schemas that couples bring into their relationship that originate from their family and life experiences (Epstein & Baucom, 1993). Each partner's perception and assumption of an event are influenced by these schemas. These inferences can be depicted in a schema diagram (Datillo, 1994) formulated using the case example (Appendix 1). The presenting issues for the couple include Rabina feeling

unappreciated and James's frustration as a result of Rabina's behaviours. Illustrated in Appendix 4 are the independent core beliefs of both Rabina and James and as a couple. These may represent the precipitating and perpetuating factors contributing to their present relationship discord. James' longer hours precipitate loneliness and rejection for Rabina. It could be suggested that her preoccupation with their lack sex are due to her wanting to get close to James to prevent cognitive distortions of dissolution and returning to a single parent. However, her approach appears to evoke pressure for James, pushing him away leaving Rabina feeling vulnerable, appearing 'needy' and further rejected. In turn, James family schemas of avoiding discussions around emotions cause James to isolate himself to evade arguments.

An additional formulation tool in CBCT is the *'five P's' model* (Johnstone & Dallos, 2006), which suggests that therapeutic goals can also be constructed using the formulation. A counselling psychologist using a CBCT formulation with Rabina and James may suggest setting therapeutic goals to alter Rabina's negative beliefs bout herself. A goal may be suggested to help James understand what he refers to as Rabina's 'nagging' behaviour. A central goal that focuses on the presenting problem could be to enhance communication and develop healthier coping strategies to prevent their bickering from escalating into acute discords.

From the examples it is clear that both models consider predisposing life experiences and relationships of the individuals, lending themselves to the presenting problem as a unit. The key difference lies in how the formulations determine the trigger that maintains the difficulties. The CBCT approach understands that ones difficulties are perpetuated through underlying schemas,

maladaptive thinking patterns and behaviours (Beck, 1976). However, in the EFT-C formulation, attachment relationships and underlying emotions are used to frame the rationale for presenting problems.

Considerations for Counselling Psychologists

Taking into consideration diverse client presentations within the assessment phase with couples is imperative for ethical affairs. CBCT appeals to couples who appreciate a model that is pragmatic and practical in approaching relationship malfunction. However, this rigidity may not be suited to all couples and the therapist may be considered egotistical due to the models didactic approach (Datillio, 2010). Although CBCT's application is widespread, research reveals its efforts are short lived (Lebow, Chambers, Christensen & Johnson 2012).

EFT-C offers a theory of love, which for the work of couples is important and is absent in CBCT among other theories (Johnson & Lebow, 2000; Roberts, 1992). Studies around EFT-C exhibit greater advantages for couples that are emotionally invested in their relationship, with the capacity to work collaboratively with the therapist. However this does not mean couples with reduced emotional mindfulness or those who lack self-expression are restricted or will not benefit from this mode of therapy (Knudson-Martin & Mahoney, 1999). EFT-C is designed to be used with couples that wish to remain as a unit, whereas CBCT can be used with couples who wish to stay together and those who wish to separate. Additionally, EFT-C is not effective when domestic violence is present within the relationship, nor when one partner expresses suicidal ideation (Greenberg & Johnson, 2010).

A major criticism for the EFT-C model is its ambiguity (Sandberg & Knestel, 2011, Ward & McCollum, 2007). There is no conclusive indication of the components required that certify substantial adjustment. Despite this, research emphasises the models long-term effectiveness, paying tribute to its clearly delineated interventions that places emphases into the context of the couples processes and responses.

Unlike CBCT, EFT-C is not 'an invariant, mechanical set of techniques' (Gurman & Jacobson, 2008, p 133). Therefore it can attend to typical relationship patterns plus couples who foster a unique relationship style. However, this can implicate timing issues for the therapist, as they must determine when to implement new interactions. A miscalculation in this area can inhibit progression and impede the therapeutic relationship (Greenberg & Johnson, 2010).

Counselling Psychologists must consider the needs of the couple and which approach they will profit from the most. In addition this should include their level of competence to provide a particular model in addition to their own preferences to prevent bias (Abbott & Synder, 2012).

Conclusion

Both models attempt to increase interaction and communication between couples. Whilst EFT-C achieves this through revealing concealed emotions, CBCT applies reattribution methods. Each model promotes awareness that can be valuable for the individual and the unit (Gurman & Jacobson, 2008). Despite the various similarities and differences between EFT-C and CBCT, both theories have shown to be effective with couples and much research has revealed that combining therapeutic models is prevalent in influencing change (Lam, Fals-Stewart, & Kelley, 2008). Counselling Psychologists have the option of combining the two modalities or using them

individually (Strawbridge & Woolfe, 2003). This ability to integrate approaches benefits counselling psychologists in that it provides them with a widespread understanding of the couple they are engaging with allowing therapy to be tailored to their needs rather than tailoring the couple to fit the therapeutic approach (Abbott & Synder, 2012). With that said further professional training within a systems approach is necessary to maintain proficient and ethical in their practice.

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Appendices

Appendix 1

Couple Case Example

Rabina and James are in their late 20's. They have been living together for four years and have two small children together (son aged 2 and daughter aged 6months). Rabina's 9 year old daughter from a previous relationship also lives with them full time and she has no contact with her birth father. Rabina left him a few weeks before her daughter was born, as their relationship was emotionally and physically abusive.

Rabina took a long time to recover from this traumatic experience, struggling to come to terms with the loss of her dreams, being a single parent and the aftermath of abuse by an intimate partner. She has a supportive family and eventually grew to enjoy being self-sufficient. She was attracted to James because he is kind, reliable and gentle and she appreciates how he has welcomed her daughter and treats her as his own. He is an excellent father and she loves being able to be a full time mum in a safe home. While she is home based Rabina is studying towards a qualification so that she is ready to return to work when their son starts school. James was

attracted to Rabina for her warmth, understanding and caring nature, and for her sense of humour.

James parents are very traditional, his mum was a housewife and his dad was the provider. His upbringing was very masculine in that thoughts and feelings were not discussed. He enjoys being a provider to his family. He works long hours and takes on extra overtime to save for a larger house. They are thinking about getting married, but Rabina is feeling very nervous about the prospect of a wedding.

James and Rabina love and care for each other and their family, but acknowledge they do not find it easy to talk about problems; James retreats, becomes quiet and withdrawn, while Rabina wants to talk things through. The couple do not have many arguments, but they are beginning to bicker about James long hours and need to save rather than enjoy their income (which is sufficient for their needs and some treats). James feels Rabina is turning into a nagging partner. Rabina acknowledges that she can be ‘needy’ and would like more support from James in the evenings when he is at home.

This is all having an effect on their sex life; James has lost desire. He says he is too tired and has had a couple of episodes where he was unable to get an erection. Rabina would like James to have a more masculine approach to their sex life. She is feeling distressed by the lack of sex, feels unattractive and has lost confidence in her body. She has become preoccupied by a high level of desire. This leaves James feeling pursued. He is also reluctant to have sex because he

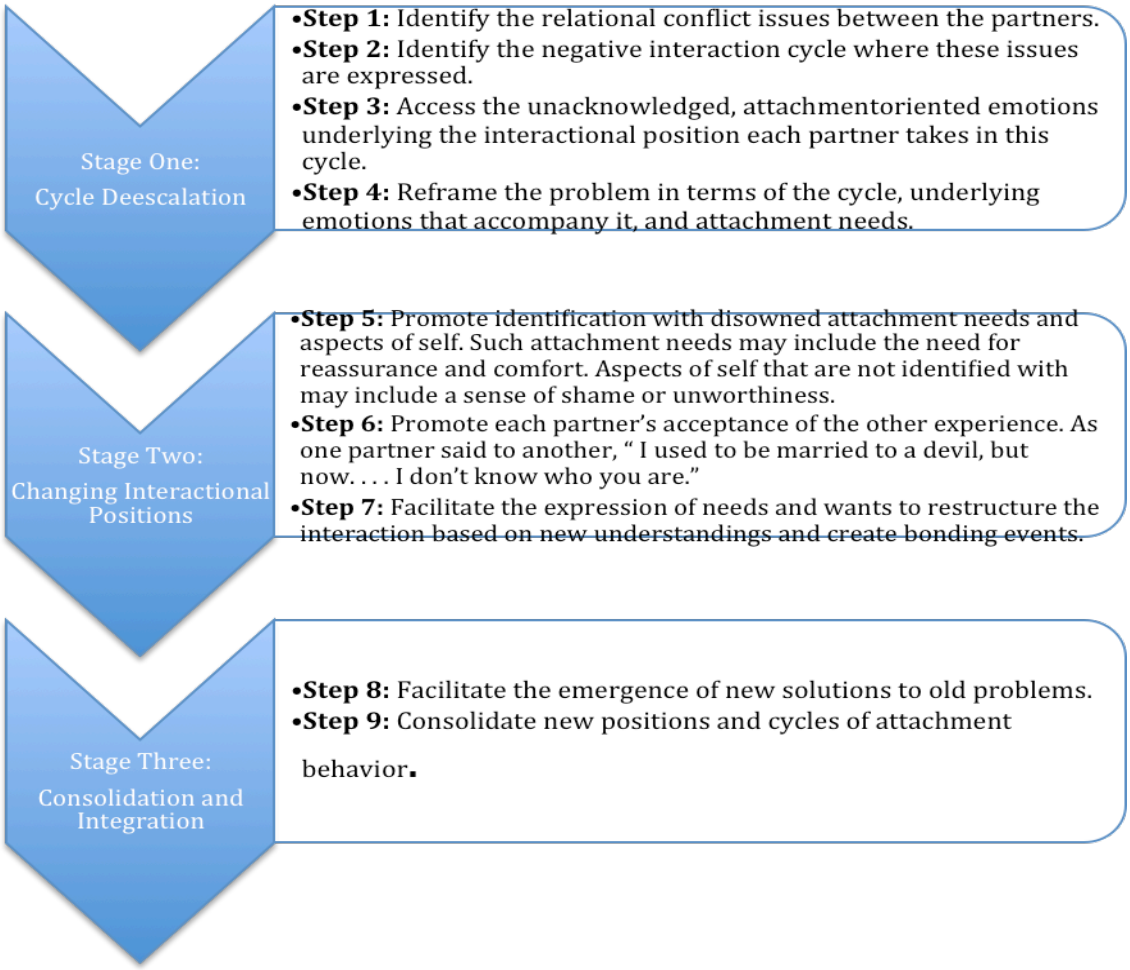
fears being overheard by his stepdaughter who sleeps in the bedroom next door but Rabina wont have sex anywhere but in their bed.

There are no underlying medical concerns, both are healthy, fit, take exercise and eat healthily. Neither is taking medication and neither some or use recreational drugs and their alcohol intake are around 4 units per week.

The couple have come to a consultation because they are wondering if their relationship is suitable and are considering cancelling their wedding plans.

Appendix 2

Phases & Stages of Emotionally Focused



Therapy with Couples

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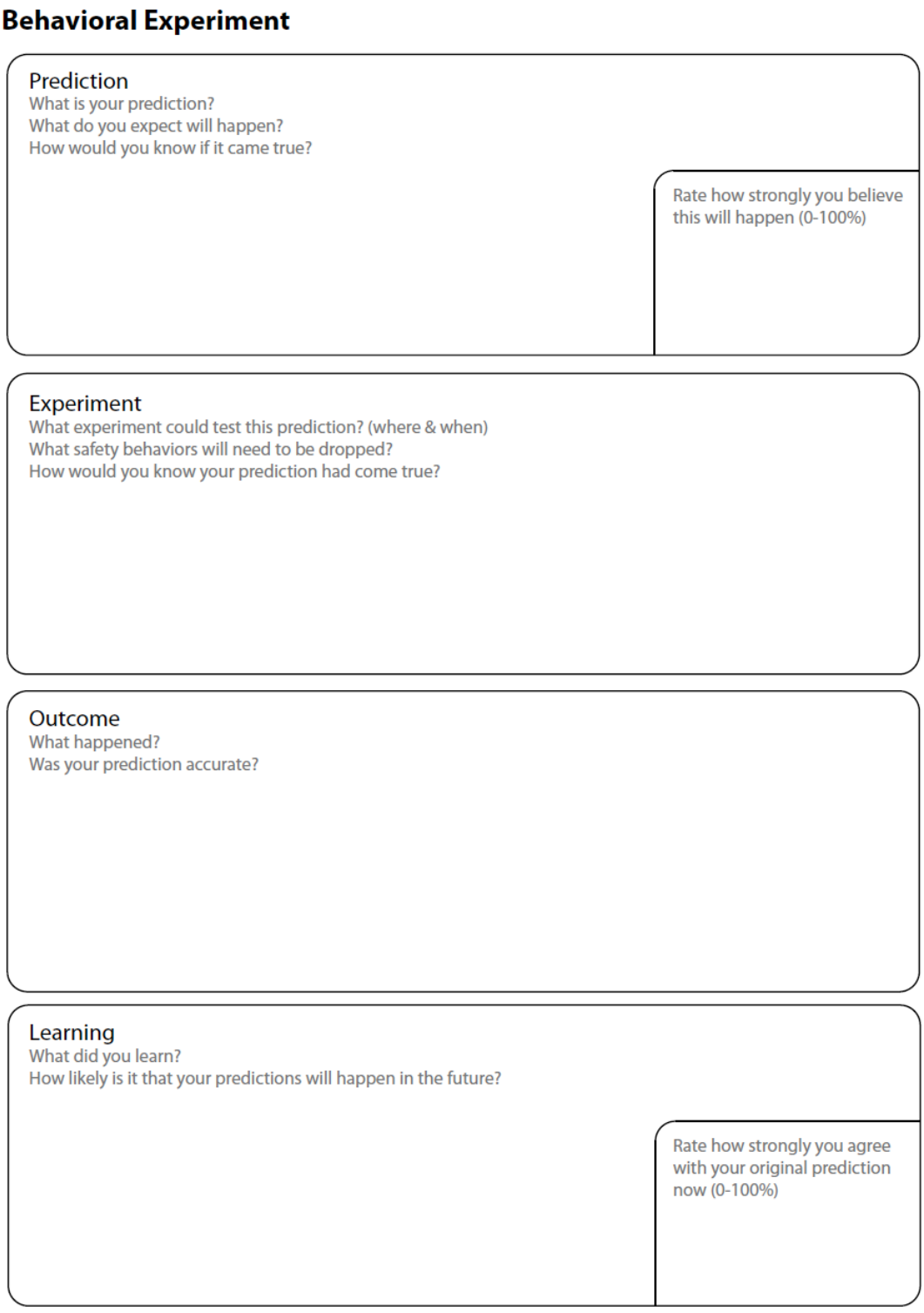
Appendix 3

Behavioural Experiment Worksheet Example



Psychology Tools. (2015).

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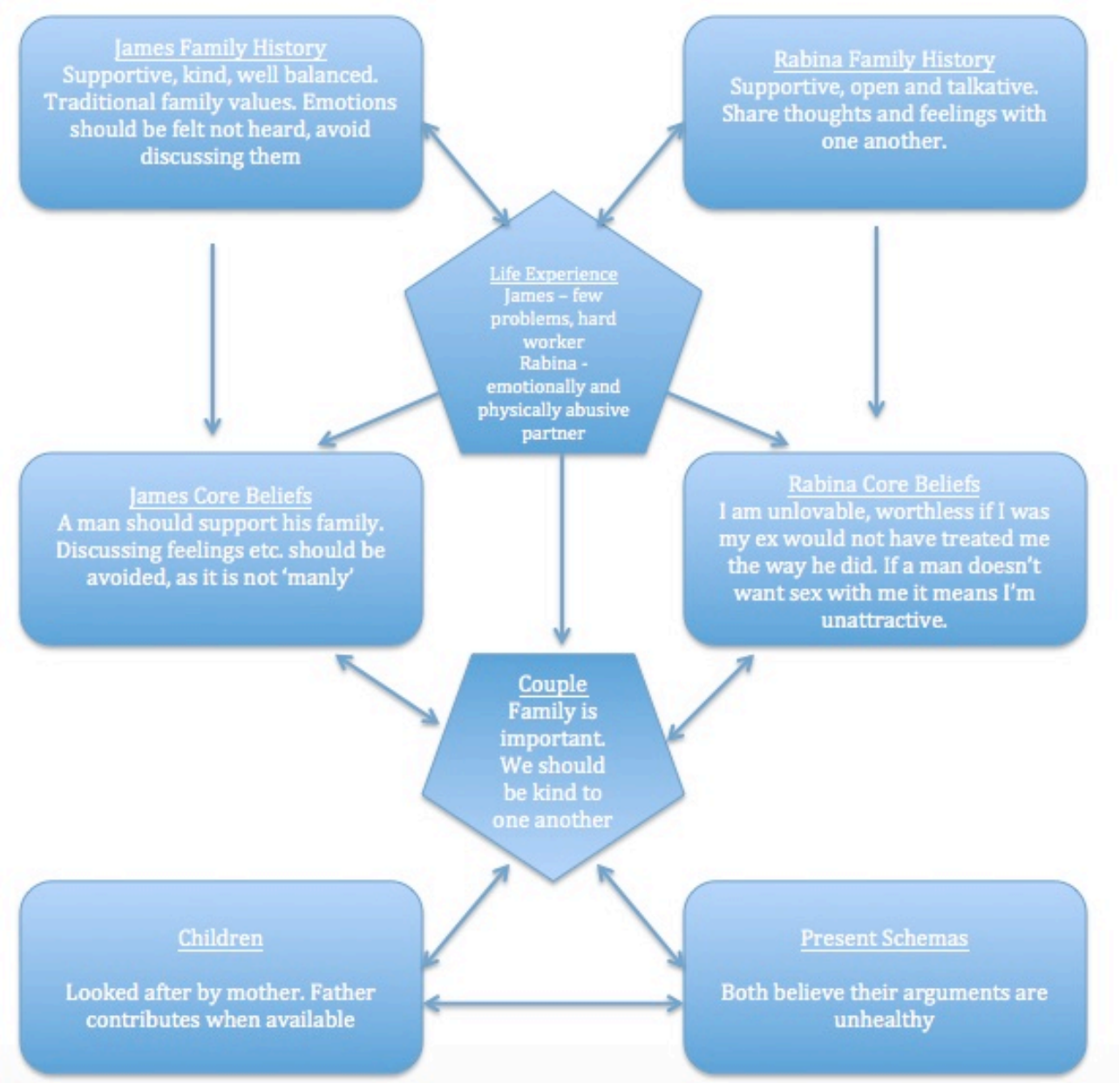
Appendix 4



Family Schema of Rabina and James

Epstein, N., & Baucom, D. H. (2002). Enhanced cognitive-Behavioral therapy for couples: A contextual approach. Washington, DC: American Psychological Association.

Appendix 5

EFT- C Interventions

Two broad styles of intervention for accessing emotional experience include:

1. Responding and 2. Directing. (See below)

Responding

A. Empathic reflection
B. Feedback on nonverbal actions
C. Evocative responding

Directing

A. Process directions and inquiries:
    1. Directing attention
    2. Directing inquiries and replays

B. Experiments in awareness.

1. Repeating key sentences
2. Directing the client to repeat phrase to heighten its impact
3. Using images and metaphors
4. Setting up contact experiments

C. Enactments

1. Vilifying enactments
2. Position enactment
3. Impasse enactment

D. Empathic interpretation of current emotional experience

1. Conjectures
2. Elaborations
3. Explications
4. Suggestions
5. Inferring catastrophic expectations

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Therapeutic Practice Dossier

Professional Issues PS5017: Reflections on Being a Professional

Introduction

A core element of the doctoral program is to reflect upon the personal development that occurs alongside the journey. Since the beginning of this course I have spent a great deal of time focusing on my personal growth and have failed to contemplate my development as a practitioner. This professional development reflection presents the opportunity for me to demonstrate my professional growth as a Counselling Psychologist throughout my training, including how I have integrated theory and practice, made use of supervision, personal therapy and research throughout the course.

History

In order to consider my professional development throughout the doctorate it seems appropriate to reflect upon how I resided here. My journey toward the doctoral program was exhausting, long and appeared endless. I forget how I knew I wanted to pursue the subject of psychology initially. However, what I do remember is that psychology was the only subject I was interested in completing whilst I was at college. Unfortunately, I never completed my A-levels and I worked for several years before I was drawn back to the area. I was adamant I wanted to study psychology and whilst working full time, I completed an evening course that would provide me with the qualification I needed to access an undergraduate degree in Psychology. I looked forward to my evening class every week and enjoyed completing the assignments. I can recall

the sheer panic I felt upon discovering that I might have been provided with false information regarding the level of my current access course and its adequacy for the university's standards. Fortunately, the course was acceptable for entry onto the undergraduate course. Upon reflection, it illuminates just how much I wanted it back then.

It was very late in the undergraduate course that I discovered the limitations of this course regarding employment within the psychology field, besides becoming an assistant psychologist. I began researching the different avenues of psychology and upon the completion of a counselling psychology module I was hooked. Determination prevailed; this was the avenue I was going to pursue. I looked into the various doctoral programmes and a recurring theme across entry requirements was the counselling certificates. I began the level two counselling skills certificate followed by level three parallel with my degree, all of which came to a head simultaneously. At that point in time I can remember feeling so proud of myself for completing a bachelors degree in addition to two further courses concurrently. When I consider the workload of those combined qualifications in comparison to the doctoral program, it feels minor. This illustrates how far I have come and how I have grown to be able to manage so much more that I thought I could.

Another criteria for the doctoral programme was age and to have worked one to one with clients. At this time I was 24, which meant I had to wait ten months until I was 25. This provided me with sufficient time to gain the experience required to meet the criteria. I managed to secure a position with the council working across several children's homes. I obtained considerable insight and knowledge during this time, which emphasised further that I was on the right journey.

When the time arrived for applications to be submitted I was extremely anxious. I felt as though my whole future depended on this and I had worked so hard to meet all the requirements that seemed to take a lifetime. To hear that the course was full for that intake was frustrating and even though I was called for an interview and received a place for the following year I felt as though my life was on pause. I used the time wisely to gain further experience and as years do, it soon came around.

Doctoral Journey

Placements

I have worked in several settings during the program including both NHS (National Health Service) and Council services. This has enabled my development by facilitating the adaptation to different ways of working inside various services with diverse client groups. Though the final outcome may be the same, the requirements differ in their route to achieving those outcomes.

My first placement was within a learning disability (LD) service in Hereford. I was really looking forward to getting stuck in and a fellow student was at the same service, which provided me with comfort that we could support one another. One-to-one client work here was limited and difficult to maintain due to dropouts and cancellations. Much of the work I engaged in revolved around triage meetings and conducting dementia assessments to which I learnt a vast amount of

information in a short space of time. I found this material valuable and significant, however, I was not connecting with the role, certainly not at this stage in my training where I was eager to exercise the humanistic skills I was learning during lectures. I felt that I was missing out on the opportunity to do so whilst it was fresh in my mind. Communication is imperative with this client group (Webb, 2013) and I felt as though this setting was inappropriate for a first year needing to hone in on those key therapeutic skills. These feelings were emphasised due to my limited experience in this area compared to others the course which ultimately led to self-doubt and listening to my critical voice. I tried to communicate with my supervisor but I did not feel she understood me. My fellow student at this same placement was doing really well and my confidence slowly began to plummet. She seemed to be getting the support she needed from her supervisor and being provided with fantastic opportunities. I took into consideration that her experience was far greater than mine but I felt as though I was slowly being left behind and I began to withdraw and get on with things myself. I was confident that the placement for me was incongruous and consequently I left. I reflect upon this now and see how despite the setting being a challenging for a first year, mastering the communication skills in this environment initially may have resulted in following settings being less of a challenge as a result of what I would have gained here.

My second placement was within the community mental health team (CMHT) in Stafford. This was a secondary care service for adults experiencing mental health difficulties across a varied spectrum. It was here that I made a significant shift within my professional development. The clients attending this service were complex and had comorbid mental health difficulties more

often than not. I learned how to unpack these difficulties with the use of formulation and treatment plans in order to make sense of them not only for myself but for the client also.

I struggled for a long time during this placement with my need to 'fix' clients in their entirety and if I did not or could not, then this meant I was still not 'good enough' and I required further training. However, through supervision I was aided to the conclusion that any change in a client's turmoil was 'good enough' as they had made improvements compared to where they were at referral or assessment. In addition this struggle came when I had less than one hundred one-to-one client hours. It was unrealistic for me to assume that I would have the expertise of a qualified professional after such a limited time with clients. My acceptance and belief of the realisation that I cannot 'fix' a client in their entirety has lead toward the development of my personal philosophy as a professional. This being that it is not my responsibility to 'fix' the client but more to work in a partnership with them so they can identify their needs and strengths in order for them to make changes for themselves.

I also did a split placement in my second year of the course alongside the CMHT in Stafford with the Shropshire IAPT (Improving Access To Psychological Therapies) team. Working within an IAPT service would provide me with the experience of functioning in a primary care setting in addition to providing short term therapy which for me was a tremendous challenge. I found this challenging for two reasons; the first resided around the fact that conducting brief therapy required me to test whether or not I had overcome my need to 'fix' clients. The second reason was that it went against my belief of short-term therapy representing a 'revolving door'. Client's difficulties are resolved temporarily but they emerge back into services in the future (Mueller &

Kennerley, 2010). I appreciate that brief therapy allows waiting lists to be targeted quicker however I believe if clients are given the time they need initially, then they are unlikely to appear in services again (Mueller & Kennerley, 2010). With these feelings aside I commenced the placement with an open mind.

My responsibilities included the facilitation of group therapy and brief one-one therapies. I felt some anxieties around delivering groups however, having delivered presentations a number of times as part of assessments on the course, I feel my anxiety fell around a 'normal' level for someone executing something for the first time. After running several groups in their entirety, I comprehended what elements of the material clients found both beneficial and unfavourable. Consequently, I implemented changes to the content and structure of the material. I observed an incredible difference to client understanding and outcomes as a result. This provided me with such a remarkable confidence boost in relation to my level of competence as a professional.

After reflecting on my development within this service, I learnt that I have the ability to work in a way I am uncomfortable with that is necessary for the service. This will become an extremely important skill when I settle within a service. There are constant changes that occur within professional contexts in order to meet guidelines and legislation whether this is through increased client load, record keeping or new management restructuring, I will be required to adapt with them regardless of any discomfort.

Currently, my placement falls within the Drug and Alcohol Recovery Service (DARS) to which I am the first counselling psychologist to work within the team. This has provided me with the opportunity to develop and promote counselling psychology within a new service by providing key workers with an alternative perspective on client presentation / difficulties. In addition, I have developed an additional therapeutic service for family members who are affected by the substance use of clients that are presently engaged in one-on-one therapies. So far, this has been well received and resulted in some powerful work.

Working with this client group is challenging for a number of reasons. DNA's (did not attend) are extremely high which interrupts the flow of therapy and holds clients who truly want the support on the waiting list. Therapy is exceptionally slow, as clients have found a way to cope and numb their emotions with substances therefore experiencing this emotion becomes painfully difficult for them and leads to avoidance during session or DNA's. Consequently, it is the therapeutic relationship that requires precedence with this client group (Meier, Barrowclough & Donmall, 2005).

Personal Development

My personal development has been infinite during the past three years and can only be described as a rollercoaster of emotions that have ultimately impacted on my professional development immensely. This has included times of doubt and times of clarity that have consequently changed me as an individual and therefore a professional. At times, especially in the early stages, these changes were perturbing however, clarity was never far behind and everything seemed to fall

into place. This process became repetitive, so that now the difficult periods are just uncomfortable but I am aware the clarity is around the corner providing me with some comfort. An early example that was deeply distressing for me was with my first therapist. Upon our initial meeting she seemed to encompass those qualities best described by Rogers (1957), as the core conditions. A spark of excitement grew inside me as not only would I witness similar qualities in her that I may one day encompass myself but I felt as though maybe someone would finally 'hear' me. Unfortunately, upon our second session I left feeling confused and wondering what had just happened. Not only had she provided me with advice but also essentially left me pondering over an ultimatum if I did not carry out the advice she had given. I attended a further 6 sessions with this therapist before leaving. This was a result of similar behaviour that left me feeling discouraged and filled with self doubt about the validity of the emotions I was experiencing. For me, this was a difficult period and prevented me from seeking a new therapist for twelve months. If I was not engaged in this course and therapy was not a requirement I'm unsure how likely it would have been for me to pursue another therapist. The clarity that evolved from this experience was a stepping-stone toward further development of my personal philosophy. This was not the type of therapist I wanted to be and it gave me insight into client's who have had a bad experience with therapists previously to which I can truly empathise with. As a counselling psychology professional it is not my responsibility to provide clients with advice, as it is me who will be accountable should that advice not work in favour for the client. It is however my responsibility to provide the client with support around what ever decision or action they decide to take.

After an extensive break from personal therapy, I began again, initially to meet the requirements of the course. However, after several months I began to trust my therapist. This has provided me with insight into how long it can actually take clients to feel safe in this environment. Yet, in the majority of NHS settings, it is unlikely that practitioners will be permitted to provide a client with this length of therapy time.

Recently, I have begun to work with my **i**nner child, which has been turbulent to say the least. It is extremely powerful work that has provided deep insight and resolution. In my experience, it has been a slow acceptance and healing process but certainly valuable and worthwhile. As a result I would certainly be influenced toward using it with clients if it was of benefit toward achieving a client's goals.

Integration of Theory and Practice

Upon commencing one-one therapies with clients, I applied theory to my practice. Initially, the focus was to adopt a humanistic approach, followed by CBT (Cognitive Behavioural Therapy), EMDR (Eye Movement and Desensitisation Reprocessing) and Psychodynamic, as this was the order I received training in for these modalities. I implemented elements of each depending on the needs for the client. For me, this is an integral part of being a counselling psychologist. No one type of therapy fits all and having the ability and option to provide therapy that is tailored specifically for them gives me the confidence as a professional to provide the support my client needs rather than making them fit into the therapy. Therefore, I feel that having a theoretical

underpinning in all areas of my work has become an unconscious process for me now. This is extremely important as it means there is evidence to support the work I am doing.

The humanistic approach, specifically Rogers' (1957), core conditions, has provided me with the foundations to build on within my therapeutic work. CBT has afforded me the tools to challenge a client's maladaptive thinking patterns and core beliefs in order to facilitate change. The psychodynamic approach has helped me to look deeper and consider other aspects of the self (within the client), for example, inner child. Transference, I feel has tremendously impacted the therapeutic environment, in that it has made me aware that the way I am feeling in the room with a client maybe in fact how the client is feeling and my awareness of it now allows me to address this if necessary.

My supervisor within the CMHT encouraged me to seek EMDR training as she was a consultant EMDR therapist and could provide me with supervision during my time there. Initially, I was reluctant to complete the training, as I believed it distanced the relationship between the therapist and the client, which, has been shown in multiple studies to be the strongest factor in enhancing therapeutic outcomes (Norcross & Wampold, 2011). Following my training I was astonished at how powerful an approach it was and how wrong I was with regards to the effect on the therapeutic alliance. This experience has taught me to have an open mind with other theories and to try them before making a judgment. I do not have to adopt all elements within the therapy; there may be one feature that will prove useful with a client, therefore making the training valuable.

Ethics

Ensuring my client work has a theoretical basis I believe, links closely with holding ethical principles in mind during client interaction. I find I intentionally ask myself if behaviours, thoughts, and interventions are ethical before utilising them (if I am worried it may not be). This to me is extremely helpful in identifying unethical behaviours, allowing them to be discussed in supervision to explore what it is I am trying to gain from the behaviour and how I might tailor it in a way that is ethical.

During the course, it has been difficult to keep abreast of the changes and developments arising within the approaches I am familiar with. However, it has been a significant part of client work in order to abide by the BPS (British Psychological Society) Code of Ethics and Conduct (2009) and the HCPC (Health and Care Professions Council) Standards of Conduct, Performance and Ethics (2008). Specifically, the code that relates to competence and working within ones scope of knowledge. If I feel a client presents with a problem that is beyond my knowledge or expertise I would either refer them to a professional with appropriate experience or explore evidence based practice methods providing the area is not entirely out of my reach.

Supervision

I have had a difficult journey with supervisors throughout my training. At the LD service I felt like a deer in headlights and did not feel I received the support I needed given I was a first year trainee. I was open with them about my condensed experience and how I felt I needed more time to enhance my communication skills. I asked to shadow my supervisor but this did not

materialise. It felt hopeless and I withdrew, continuing where I could independently. Reflecting upon this now, I am aware how exceptionally unhealthy this was/is for any professional, especially a trainee and conflicts with ethical guidelines.

My second supervisor was the director of psychological services and both clinical and structured in his method of workings. After observing him several times, I questioned his approach toward clients, which I viewed as direct, and lacking empathy. I felt restricted in my client work and he required detailed notes of every session I had with a client in addition to the case notes. This made me feel like a child and under scrutiny often making me panic about the choices I made in sessions for the fear of them being wrong. This was extremely unhealthy for me and for my clients, as I was not fully concentrating on the client. In hindsight, I feel this communicated that my instincts were aware of something I was not consciously. His clinical approach was incompatible with me, emphasising how counselling psychology was certainly the right choice for me. Nevertheless, I am aware that not all clinical psychologists work in this manner but the therapeutic approach promoted within counselling psychology is compatible with the way I wish to work.

My second supervisor was on leave and I had a replacement for this time. I felt she was my saving grace. She saw the life being sucked out of me, taking me under her wing and becoming my new supervisor. I am eternally grateful for the ways in which she has helped me. She was nurturing in a professional way and trusted not only my judgements but also that I would go to her if I encountered any difficulties rather than coping on my own. She made this an easy process as she was non judgemental, therefore if I felt I had done something wrong I would not hesitate

to go to her. She has encouraged me to see the qualities I hope to posses as a supervisor. She gave me the space to breath and freedom to use a multitude of interventions, enabling me to grow and develop in order to learn who I was as a practitioner and the type of practitioner I could and wanted to be.

Upon meeting my fourth supervisor, I was clear about what I needed from her as a supervisor and from the placement. As a result of my struggle in previous placements I knew what I needed to succeed and this time I felt confident to ask for it knowing the end result if I did not. She has provided me with a new perspective of working and has assisted me through my struggle with a particular client group. In addition, she has helped me to see I am a competent professional through the consideration of my ideas for her own client work. I value her respectful approach to both clients and fellow colleagues, thus encompassing favourable traits I'd like to see within myself as a professional.

During the experiences I have encountered with several supervisors, I have learnt how to ask for what I need in order to meet my needs that allow me to practice under BPS Code of Ethics and Conduct (2009) and (HCPC) Standards of Conduct, Performance and Ethics (2008). This is not something I would have been able to do before my training. In addition, I have the ability to adapt accordingly to work and engage with others and their modes of working. Working with several supervisors has given me direction toward the type of supervisor I would like to be and the qualities I hope to possess.

Research

Attachment can be viewed by some (including myself) to be at the very core of whom we are, as it impacts our every encounter with another human being. Given my passion for knowledge and understanding for how we as individuals behave, I was intrigued by the attachment theory as it is initiated from the day we are born. Some even suggest it occurs within the womb (Brandon, Pitts, Denton, Stringer & Evans, 2009). In order to meet the requirements for the thesis I had to consider attachment in relation to counselling psychology. Therefore, I decided to consider attachment within the therapeutic environment and the role it may play. In one-to-one therapy, there are two attachment styles within the room (client & therapist). I was interested to know whether the interaction of these attachment styles affected the outcome of therapy and the therapeutic relationship. During therapy with my clients, I have noticed how there are some that I have deeper interactions with than others and it would be enlightening to know whether this is as a result of the interaction of particular attachment styles holding more compatibility. Following Brennan, Clark & Shaver's (1998) theory of attachment, there are four attachment styles, resulting in eight possible attachment style interactions that might affect the outcome of therapy. The aim of this research is to determine whether certain attachment style interactions generate enhanced therapeutic outcomes and relationships compared with other interactions. Essentially, the results of this research may well assist psychological health services in reducing drop out rates and improve outcomes through pairing clients with a therapist possessing a complimentary attachment style.

Where I Am Now And Where I Want To Be

Currently I am a budding Counselling Psychologist in the final stretch towards qualifying. I assumed in previous years that I would be working for a salary by now, however there have been considerable changes within health sectors whilst I have been on my journey that have restricted this possibility. Therefore my first aspiration is to gain employment. Following this, I would like to complete my EMDR training and become accredited in order to continue my professional development. Having received small amounts of training in multiple approaches, CPD (continuing professional development) I believe, enables professionals to seek additional training around there interests, client needs and to restore any areas that they feel they have lost touch with. With this in mind, I would like to complete further training around the psychodynamic approach with the purpose of gaining deeper knowledge, as I feel it can be easily integrated into multiple facets of therapy.

With the intention of expanding my expertise, I would like to complete eyewitness testimony training and add more depth and variety to my practice. I also intend to complete the BPS supervision training to ensure I can provide future trainees with earnest support. Finally, I am enthusiastic about the research I am conducting and would like to extend this research to further uncover whether attachment styles are static and whether they are liable to change following therapeutic intervention. Overall I am looking forward to focusing on the areas I have drive for that will in turn help my clients. If I am enthusiastic about an intervention or therapy and believe in it, I think this will translate to clients, providing them with the confidence to try it.

In terms of my personal development moving forward, I hope to continue with personal therapy, as I believe this will only facilitate more awareness. Over the last three years of training I have collected a mound of books that I have been eager to read to facilitate both personal and professional development that have been put on hold to allow the course to take priority.

In regards to counselling psychology, my personal philosophy that has developed over the course of my training is: to approach each client as an individual, tailoring therapy accordingly and to work in a partnership with clients, supporting them on their journey.

Conclusion

By no means has this journey been an easy feat. However, I would not be the professional I have grown to be without the struggles, hurdles or accomplishments, nor would I be the individual I am. These changes have not been comfortable but through the transition, I have been provided with awareness of what my clients experience. I believe through the maintenance of research, supervision, professional practice and personal therapy, I will continue to grow as a practitioner within the counselling psychology sector. I look forward to pursuing the professional journey my future has to offer.

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Professional Portfolio

Counselling Psychologist in Training

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Introduction

This portfolio provides a comprehensive insight into the training and experience I have gained on my journey towards becoming a counseling psychology professional. I have had the opportunity to work in several contexts, which has enabled me to work with a wide spectrum of client difficulties thus expanding my knowledge, experience and reflective practice.

I am an enthusiastic, resilient, and conscientious practitioner. I strive for growth where possible and utilise every occurrence as an opportunity for learning and development for the client and myself. I am a dedicated individual who continues to work to the scope of my knowledge, core competencies and within the ethical frameworks of my professional affiliations with the British Psychological Society (BPS), Health Care Professions Council (HCPC), and Division of Counselling Psychology (DCoP).

My journey to date has significantly influenced my professional identity and personal qualities. I look forward to what the future, of this journey may hold.

Profile

Qualifications

Working towards Practitioner Doctorate in Counselling Psychology

BSc. (Hons) Psychological Sciences (2:1)

Research: Congruence and the presentation of actual self among avatars

Training

EMDR L2

EMDR L1

Counselling Skills L2

Counselling Skills L1

Employment History

NHS Secondary Care CMHT

NHS Primary Care IAPT

Drug and Alcohol Recovery

Counsellor

Professional Affiliations

British Psychological Society (BPS): Graduate Member

Division of Counselling Psychology (DCoP)

EMDR Association: Trainee Member

Working towards HCPC accreditation

Personal Qualities

- Proficient and well organised
- The ability to work autonomously and as part of a team

- Adaptable and versatile
- Able to maintain professionalism in highly emotive environments and able to initiate development.

Organisational Context

The Council

The council communicates with an adjacent NHS trust to provide mental health services. Adult Mental Health services are available to anyone aged over 18, living within the council's borough and registered with a GP in the area. If an individual requires mental health services they can access them by going to their GP or other health and social care agencies who will pass on their details to the Community Mental Health Teams (CMHT). The CMHT will provide the individual with a care coordinator who oversees the individuals care including directing them to the services they need e.g. drug and alcohol recovery.

NHS Secondary Care

Psychology within Secondary Care comprises of Community Mental Health Teams (CMHTs), Crisis Resolution and Home Treatment Teams (CRHTs) and Assertive Outreach. The work of a psychologist includes direct work with clients, involving the provision of a range of specialist, evidence-based psychological assessments and interventions for those with acute Mental Health difficulties. Clients seen by psychologists typically have complex and/or longstanding mental health difficulties including psychosis and mood disorders. The intention is to contribute to the promotion of recovery by using evidence based approaches in combination with the client's own experiences, strengths and resources. This is further facilitated through multidisciplinary working to provide client stability.

Community mental health teams (CMHTs) are multidisciplinary, multi-agency teams offering specialist assessment, treatment and care to adults with mental health problems, both in their own homes and in the community. They work with people often described as having complex needs – for example, in relation to housing and homelessness, benefits, unemployment, use of drugs or alcohol, or those who have had contact with the criminal justice system. CMHTs aim to provide the day-to-day support needed that allows a person to live in the community. Teams may provide a whole range of community-based services themselves, or be complemented by one or more teams providing specialist functions.

NHS Primary Care (Clinical Commissioning Groups; CCGs)

Primary mental health care offers first line interventions that are provided as an integral part of general health care, and mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services.

The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. It provides clients with a realistic and routine first-line treatment, combined where appropriate with medication. The programme is open to adults of all ages and the therapy available will usually be a course with a fixed number of sessions of a particular type of therapy, such as cognitive behavioural therapy (CBT).

In Training Placements

South Staffordshire and Shropshire Healthcare, Telford & Wrekin Council

Drug & Alcohol Recovery Service (DARS) Oct 2014 - Ongoing

Context

Shropshire Community health NHS Trust works in accordance with Shropshire Council and Telford and Wrekin Council to provide a clinically-led service offering treatment and specific interventions to individuals with substance misuse needs. The service offers open access triage assessment of both drug and alcohol use and provides comprehensive treatment to enable the individual to work towards recovery. The service comprises of several professionals including social workers, nurses and psychologists. It provides clients with detox and rehabilitation programmes and substance maintenance. Clients are offered healthcare assessments including blood-borne virus testing and immunisations with referral on to other treatment if appropriate.

Clients

Referrals are made to the service via GPs, other health professionals and partner organisations. The service also provides an open access/drop-in clinic daily for self-referrals. Clients are assigned a key worker who makes a referral to the psychological department if psychological input is required.

The majority of clients within the service experience mental health difficulties alongside alcohol and/or drug addiction/recovery. The mental health difficulties are both long standing and unresolved in addition to recent stressors which include; depression, anxiety, bereavement, history of abuse and domestic violence to name a few.

Therapeutic Approach

Therapy within this context is guided by the client initially in order to maintain engagement and establish a sound therapeutic alliance. NICE guidelines recommend CBT and motivational interviewing (MI) for this client group. However, an integrative stance is adopted to incorporate NICE guidelines and client need. A humanistic approach provides the foundation for the therapeutic environment. What comes next is dependent on client goals and the best approach for the client in order for them to achieve these goals e.g. many clients have a history of trauma therefore where appropriate EMDR is used.

Supervision

My supervisor within this placement is a clinical psychologist with a background in both in-patient services and drug and alcohol recovery services. Individual supervision provided fortnightly and informally if and when I require her support. Areas of discussion include: Supervision occurred within the following domains:

- Client issues, formulation, and therapy
- Case management
- Risk assessment and management.
- Personal reflection
- Service updates

Roles & Experiences

Psychological Assessment	Employed semi structured idiographic assessments.
Formulation	Used formulations derived from evidence-based practice, treatment plans, and transdiagnostic methods.
Provision of Therapy	An integrative therapeutic approach is adopted using several approaches including CBT, humanistic, EMDR and psychodynamic.
Screening and Assessment	Accountable for a case-load of referrals, to offer psychological assessment and determine suitability for treatment. In addition I assist in managing the waiting list.
Multidisciplinary team working	Liaised with other professionals to share vital information, to coordinate support, and to further facilitate engagement and progress within therapy.
Risk Assessment and management	Risk was measured through the use of psychometric tests and awareness of risk factors. Concerns surrounding the welfare of clients or third parties is coordinated alongside the client's key workers and the care plans they derive.
Constant awareness of Changes within the Service	Attained through attending monthly team meetings.

NHS Primary Care

The Improving Access to Psychological Therapies (IAPT) September 2013 – May 2014

Context

This placement was an IAPT service, which offered a range of psychological therapies to people with low mood, anxiety and other common psychological difficulties. Counselling, art therapy and Cognitive Behaviour Therapy (CBT) were the most common forms of treatment provided. The service was made up of PWP's, CBT therapists and psychologists, providing short-term individual therapy of 1-6 sessions in addition to group therapy.

Clients

Clients were referred by their GP or via self-referral. Telephone assessments were completed to establish whether the client required individual treatment or if group treatment was sufficient as an initial port of call. Groups focused on bereavement, self-esteem, anxiety and mindfulness. Client's were adults (18+) seeking support for mild anxiety and depression as a result of recent stressors.

Therapeutic Approach

CBT was the therapeutic approach adopted within this service as recommended by NICE best practice guidelines for this client group with mild/moderate anxiety and/or depression. Clients were offered a total of six sessions, which could be extended if unequivocally necessary.

Supervision

My supervisor within this placement was a CBT and Art Therapist with ten years of experience of working with those accessing primary care services. Individual supervision was provided in a ratio of 1 hour per every 8 client hours. Areas of discussion included:

Supervision occurred within the following domains:

- Client issues, formulation, and therapy
- Case management
- Risk assessment and management

Roles & Experiences

Psychological Assessment	Employed semi structured idiographic assessments.
Constant awareness of Changes within the Service	Attained through attending monthly team meetings.
Formulation	Used formulations derived from evidence-based practice, treatment plans, and transdiagnostic methods.
Provision of Therapy	The therapeutic approach adopted was CBT in both individual therapy and group therapy. Employed cognitive behavioural therapy treatment Plans suggested by Leahy and Holland (2000) Treatment Plans and Interventions for Depression and Anxiety, and Wells (1997) Cognitive Therapy for Anxiety Disorders.
Screening and Assessment	Telephone assessments to screen client need and suitability/openness to group therapy or individual therapy.

	Accountable for a case-load of referrals, to offer psychological assessment as part of the course of treatment.
Multidisciplinary team working	Liaised with other health care professionals to coordinate support.
Risk Assessment and management	Risk was measured through the use of psychometric tests and awareness of risk factors.
Constant awareness of Changes	Attained through reading the monthly Trust E-Letter, and liaising with team manager.

NHS Secondary Care

Community Mental Health Team May 2012 – May 2014

Context

This placement was a Multi-Disciplinary Team (MDT) involving clinical and counselling psychologists assisting with psychological areas of mental health in the form of group therapy or individual therapy alongside psychiatrists who assisted with medication and social workers who assisted with housing and benefits.

Therapy was determined through NICE best practice guidelines. It was time-limited and reviewed every twelve sessions, although this was dependent on client presentation at assessment. The client group comprised of adults from a variety of ethnic backgrounds, diverse

life, social, and cultural experiences. Adults were aged 18 years and above and were considered to have mental health difficulties requiring secondary care services.

Clients

Clients were largely referred for psychological assessment from within the CMHT as a result of involvement with other areas of the team such as psychiatrist, care coordinator or both in most cases. Clients were also referred from other specialist community services, such as GP, Crisis Intervention, or child / adult social services.

Client difficulties included depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, atypical eating disorder, personality disorder, abuse and trauma, transgender and sexual identity issues. More often than not client difficulties were comorbid and could involve several difficulties at the same time and were frequently maintained or exacerbated by prior or current social circumstances.

Clients presented with moderate to high risk of deliberate self-harm, suicidal ideation and behaviour, and risk to others.

Therapeutic Approach

An integrative approach to therapy was adopted within this context with guidance from NICE best practice guidelines and direction from client need/goals. Clients were offered 12 sessions initially, to which this could be extended if necessary following a review session. Humanistic undertones provided the foundation for all therapeutic encounters and client need directed the implementation of additional approaches. E.g. EMDR for trauma, CBT for OCD etc.

Supervision

My supervisor within this placement was a consultant counselling psychologist with an extensive background in managing, operating, and delivering psychological therapy within secondary care mental health. Individual supervision was formally offered weekly and informally if and when I required her support. Areas of discussion included:

Supervision occurred within the following domains:

- Client issues, formulation, and therapy
- Case management
- Risk assessment and management.
- Personal reflection
- University demands
- Service transformation updates and management

Roles & Experiences

Psychological Assessment	Employed semi structured idiographic assessments.
Formulation	Used formulations derived from evidence-based practice, treatment plans, and transdiagnostic methods.
Provision of Therapy	An integrative therapeutic approach was adopted using several approaches including CBT, humanistic, EMDR and psychodynamic.
Screening and Assessment	Accountable for a case-load of referrals, to offer

	psychological assessment and recommendation of needs in order to refer to suitable professionals and Services. In Addition, responsible for managing waiting list.
Multidisciplinary team working	Liaised with other health care professionals to share vital information, to coordinate support, and to further facilitate engagement and progress within therapy.
Risk Assessment and management	Risk was measured through the use of psychometric tests and awareness of risk factors. Concerns surrounding the welfare of clients or third parties were coordinated alongside other health care professions, GP's and Crisis Intervention.
Constant awareness of Changes within the Service	Attained through liaising with other, health care professionals, reading the monthly Trust E-Letter, and recording committee meetings minutes.

Core Competencies

Skills

- Excellent verbal and written communication skills
- Ability to work in a multidisciplinary environment
- Experience of delivering workshops and presentations
- Ability to be an autonomous, reflexive and critical practitioner
- Ability to remain composed is stressful environments

Knowledge

Assessment	Proficient at using structured, unstructured and semi-structured psychological assessments for a variety of client presentations.
Formulation	Ability to apply evidence-based, transdiagnostic, and idiographic formulations to comprehend a variety of client presentations.
Therapy	Ability to employ a number of psychological approaches, including CBT, humanistic-existential, psychodynamic, and EMDR.
Research	Ability to use both qualitative and quantitative research methods. Ability to analyse, interpret, and disseminate research outcomes. Competent at using SPSS, a popular statistical software package.
Contexual Awareness	Experience of interacting with clients within

	several settings, including community and outpatient. Experience of working within a culturally diverse context. Awareness of organisation policy and legislation within psychology and mental health. Able to identify and employ clinical governance, as appropriate, to support and maintain clinical practice
Ethical practice	Ability to work ethically, as defined by the HCPC (2012), BPS (2009), and DCoP (2005). Ability to be ethically aware in clinical practice and apply this in decision making to research and clinical practice.

Framework for Learning

Reflective Practice	Personal development group Supervision Personal therapy
Skills Development	Role-play In-training placement experiences Video (audio) assessment Observation Presentations

	Workshop lecture
Knowledge Development	Dyadic and dialectical learning
	Lectures, seminars, and tutorials
	Report writing, policy, and documents
	Conferences

Continued Professional Development

Training & Workshops

EMDR Extra

EMDR Level 2	(Manda Holmshaw)	2014
EMDR Level 1	(Manda Holmshaw)	2013

University of Wolverhampton

Test User Occupational: Ability (Level A)	2014
(Debbie Stevens-Gill)	
Test User Occupational: Personality (Level B)	2014
(Debbie Stevens-Gill)	

BPS

Trauma Focused CBT (Dr Heather Sequeria)	2012
Anxiety Traps (Christine Padesky)	2011

University of Bolton

Counselling Skills L2 (Trudy Weldon)	2010

Counselling Skills L1 (Trudy Weldon)	2009

Professional Training

NHS SSSFT

RIO champion user training	2014
IAPTus	2013
Safeguarding vulnerable adults and Children	2012
Information Governance	2012

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BPS. (2009). Code of Ethics and Conduct. Leicester: British Psychological Society.

Division of Counselling Psychology. (2005). Professional Practice Guidelines. Leicester: BPS.

HCPC. (2012). Guidance on Conduct and Ethics for Students. London: Health & Care Professions Council.

Leahy, R. L., & Holland, S. (2000). Treatment Plans and Interventions for Depression and Anxiety Disorders. New York: Guilford Press.

Wells, A. (1997). Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide. Chichester: Wiley

RESEARCH

DOSSIER

The Impact Of Client And Therapist Attachment Styles On The Therapeutic Relationship And Client Outcomes

Chapter 1 - INTRODUCTION

This thesis explores the relationship between client and therapist attachment orientation, the therapeutic relationship and therapeutic outcomes (greater reduction in symptoms of depression and anxiety following therapy sessions). To do this efficiently, three papers are presented separately and include a literature review, an empirical research study, and a critical appraisal of the research process.

In the literature review, a narrative evaluation of attachment theory development and attachment within the therapeutic environment is delivered. Using existing research to explore the therapist as an attachment figure, the impact of both the client and the therapist on the therapeutic relationship and therapeutic outcomes, the link between attachment and psychopathology, along with existing research that has used attachment theory to match the client and therapist to facilitate an enhanced therapeutic environment.

The empirical research study examined the interaction between client and therapist self-reported attachment style and the impact of this on client outcome and on therapeutic alliance. The aim of the analysis was to identify which attachment style combinations (attachment of the client interacting with the attachment of therapist) provided a stronger therapeutic relationship and which produced a greater reduction in symptoms of depression and anxiety. It was hypothesised that a particular combination would provide a stronger therapeutic relationship compared to others and that a particular combination would provide a greater reduction in symptoms of depression and anxiety. Thirty-eight client and therapist participants were recruited from private therapeutic services. Client and therapist participants completed a measure of attachment at session one of therapy and a measure for the therapeutic alliance at session six.

Clients also completed measures of anxiety and depression at session one and six of therapy. Regression analysis was used to determine an interaction between client and therapist attachment styles and the impact of this on the alliance and change in symptom severity. Results found Client and therapist alliance raw scores explained 15.3% of the variance for changes in depression. This variance increased to 30.7% for changes in depression when single indicators of attachment were introduced. The interaction of client and therapist attachment styles explained no variation with therapeutic outcomes. Results also found clients' perceived alliance contributed significantly to a reduction in depression and anxiety. Therapists exhibiting a secure attachment had stronger therapeutic relationships and clients displayed a greater reduction in symptom severity when their therapist was securely attached. Clinical implications, limitations, and future research are also discussed.

The critical review reflects upon the research process for the author. The rationale for the literature review and research paper are outlined before addressing the considerations for the methodology of the study. The implications that this research has upon therapeutic practice are then considered followed by suggestions for future research and a personal reflection of the research from the author.

Chapter 2 - LITERATURE REVIEW

2.1. Abstract

This narrative review appraises research that has examined the relationship between client attachment, therapist attachment, the therapeutic alliance and changes in client symptom severity through the therapeutic process. Findings illustrate significant associations between therapist attachment orientation, the therapeutic relationship as perceived by the client and therapist and clinical outcomes. However, these results are ambiguous, as some place emphasis on the client while others focus on either the therapist or a combined client-therapist contribution. A consistent finding was the positive correlation between therapists who are securely attached holding stronger therapeutic relationships and a negative correlation between therapists who are securely attached and symptom severity.

2.2. Introduction

A breadth of research focuses its attention on the reason behind client improvement as a result of therapy. A consistent variable among all therapeutic encounters is the therapeutic relationship, which is an interpersonal interaction between a client and a therapist. However, included within this relationship are the therapeutic approach employed, therapeutic interventions utilised and client and therapist characteristics among others. All of which have been studied to determine their impact on the therapeutic outcome (reduction of psychological distress following a number of therapeutic sessions). Attachment theory has been regarded as a model in which to understand the therapeutic relationship. An attachment relationship can be described as an emotional bond linking one individual to another across space and time (Ainsworth, 1979; Bowlby, 1969). An attachment to another does not have to be reciprocated and several researchers consider the

therapeutic relationship to be an attachment relationship (Bowlby, 1988; Mallinckrodt, 2000; Parish & Eagle, 2003) Attachment to another is most commonly observed in times of distress when an individual in need approaches an attachment figure to feel safe (Bowlby, 1973). These attachment relationships are developed in infancy with primary caregivers and are considered to hold significance across the lifespan (Bowlby, 1973). Depending on how a caregiver responds toward their infant in times of need depends on how an infant responds to others they encounter. For example, a securely attached infant's needs are responded to appropriately and infants who have experienced this from caregivers are likely to be adults who see attachment figures as being available and responsive (Bowlby, 1980). In contrast, an infant with an insecure style of attachment is unsure whether their attachment figure will respond to their needs or not and these infants are likely to be self-critical and insecure adults who require reassurance from attachment figures (Shaver & Clark, 1994). Attachment is interlinked with emotion regulation. Emotions stimulate physiological, behavioural and experiential response tendencies that collectively influence the ways in which we respond to opportunities and challenges. Emotion regulation is the process that influences the emotions we have, when they occur and how we express them (Gross, 1998). Emotions are built of many components that evolve over time. The regulation of emotions includes changes within the dynamics of emotions such as intensity and duration. The inconsistency and low self-worth described for an individual with an insecure attachment can affect their emotions and lead to distress. As a result, attachment can also be a foundation in which to understand one's vulnerability to psychological distress.

The rationale for this study is to gain further understanding around the therapeutic environment and how a lifespan theory impacts this environment. In addition, it is important to contribute to existing literature by providing support to existing literature and provide new

information. This being that the attachment of one individual impacts another and in turn affects the therapeutic outcome.

The importance of this research lies in improving the therapeutic encounter for both the client and the therapist. For example, if pairing client and therapist with regards to attachment orientation means the client experiences a better service then this warrants exploration for the benefit of future clients and health care professionals. Since previous research has focused primarily on the impact of the client's attachment within the therapeutic environment, this research and review may emphasise any impact the therapist's attachment has on the environment. In turn, this will bring awareness to therapists' with regards to the effect they have on the environment and relationship.

The purpose of this literature review is to provide a detailed account of previous research that contributes to the rationale for the current study. A narrative of attachment theory and its development will be followed by a discussion of its presence within the therapeutic environment. It requires consideration that throughout the narrative the term 'therapeutic outcomes' refers to changes following sessions of therapy and not changes at the end of therapy unless otherwise stated.

2.3. Attachment Theory

Over the last four decades, John Bowlby's (1969) theory of attachment has developed into a prominent theoretical framework that facilitates the understanding of personality, social development and close relationships (Cassidy & Shaver, 2010). Bowlby's initiation of attachment theory arose from his attempt to comprehend two boys who had difficulties amidst the relationships with their mothers, which led him to believe that disruptions within the mother-

child relationship are antecedent of psychopathology in later life. Following his observations of infant behaviour when separated from their mothers, he noticed their intense distress despite the availability of others. He witnessed the extent, to which the infant would go to avoid (e.g., crying, clinging) or re-establish (frantically searching) proximity to their mother (Cassidy & Shaver, 2010). Psychoanalysts argued that this behaviour was an expression of immature defence mechanisms that the infant uses to repress emotional pain. However, Bowlby contended that this behaviour could be seen across a variety of mammalian species and contemplated the possibility of the behaviours holding an evolutionary function. Bowlby extrapolated from ethological theories, hypothesising that these attachment behaviours (searching and crying), were adaptive reactions to separation from the primary caregiver (attachment figure), which provided the function of keeping the caregiver proximal. The caregiver is defined as the one who provides care, support, and protection. Infants (human or mammalian) are incapable of providing these needs for themselves; they are dependent upon 'older and wiser' adults to meet these needs (Cassidy & Shaver, 2010). Bowlby contended that attachment is adaptive as it heightens an infant's chance of survival (see Harlow, 1958 and Lorenz, 1935).

The motivational system that Bowlby termed the attachment behavioural system is a significant element within attachment theory due to the theoretical link it provides between ethological theories of human development and modern theories of personality and emotion regulation. For example, Bowlby asserted that an infant's attachment system assesses the proximity of the attachment figure. If the attachment figure is available, the infant feels secure, loved and confident. In addition, they are likely to interact with others socially and playfully. However, if the infant feels their attachment figure is unavailable they are likely to feel anxious and display attachment behaviours from searching to crying. The infant continues this behaviour

until proximity is re-established or until they give up. The latter is common in circumstances of prolonged separation or loss, which can lead to depression (Fraley, 2007). There are four main characteristics of the attachment system proposed by Bowlby. The first, proximity maintenance is described above and facilitates individuals to manage stress-inducing situations by maintaining closeness to attachment figures. The caregiver or attachment figure serves as a safe haven, which is the second feature of the system and is where individuals can return for comfort in moments of stress. The third feature is the secure base that affords an individual to explore their environment advancing their character in a supportive setting. Finally, separation distress is when one experiences stress or anxiety when the attachment figure is not in close proximity. Bowlby (1988) asserted that this system functions throughout the lifespan and is expressed in a person's behaviours and thoughts that are associated with maintaining proximity (Mikulincer, Birnbaum, Woddis, & Nachmias, 2000).

While Bowlby proposed that the above describes the foundations for the attachment behavioural system, he acknowledged that individual differences have some significance in the way in which infants evaluate the availability of their attachment figure and how their attachment behaviour is controlled when threats are apparent (Fraley, 2007).

Ainsworth (1979) studied this area of individual differences by exploring infant-mother separations. She developed a method known as the strange situation, which has now been applied to observations of over several thousand infants and their attachment figures (Bowlby, 2005). Infants and their caregivers were observed in a laboratory setting firstly with their caregivers, then alone and finally upon their caregivers' return. Ainsworth (1979) derived three attachment styles from this experiment which she considered to be the result of early interactions with the attachment figure; these were, secure, insecure avoidant and insecure anxious (McLeod, 2008).

Over half of the infants observed behaved how Bowlby indicated in his normative theory described above and are defined as a secure attachment (Fraley, 2007). The behavioural and psychological characteristics of each f these attachment styles will be briefly outlined.

Securely attached infants are confident that their needs will be met by their caregiver and are free to explore their surroundings using the caregiver as a secure base if they encounter any distress (Main & Cassidy, 1988). The infant is pacified with ease when distressed. A secure attachment is established when the attachment figure is perceptive and takes appropriate action in response to their signals and needs. Consistency is also key. Bowlby (1980) affirmed that those who have experienced a secure attachment are "likely to possess a representational model of attachment figures(s) as being available, responsive and helpful" (Bowlby, 1980, p. 242).

Infants with an insecure avoidant attachment strive for physical and emotional independence, they do not assess the proximity of their caregiver while exploring their surroundings (Behrens, Hesse, & Main, 2007) and they refrain from pursuing their caregiver in times of distress. Attachment figures of these infants are likely to be unresponsive and reject their needs (Ainsworth, 1979). The caregiver may abandon the infant in the midst of challenging tasks (Stevenson-Hinde & Verschueren, 2002) and remain absent when the infant is emotional distressed (Gleeson & Fitzgerald, 2014).

Finally, insecure-anxious infants are behaviourally ambivalent towards their caregiver. During interactions they are both dependent and rejecting toward the attachment figure. The infant is unable to acquire any sense of security from the caregiver. Consequently, they struggle to separate themselves from their caregiver to explore their environment. They are difficult to console in times of distress and interaction with the attachment figure offers no contentment.

This behaviour occurs as a consequence of the attachment figure responding inconsistently to their infants needs (Gleeson & Fitzgerald, 2014).

The relationship between an infant and their primary attachment figure leads to the internal working model (IWM) developing (Bartholomew, 1990; Bartholomew & Horowitz, 1991; Bowlby, 1969). This cognitive framework encompasses mental representations that are used to understand one's self, the world, and others. Memories and expectations from the internal working model (IWM) guide an individual's interaction with others, which assists in their evaluation of this contact (Bretherton & Munholland, 1999). These memories are the result of two key components. The first being the responsiveness of attachment figures ability to tend to proximity seeking behaviour and the second being the ability of oneself to succeed in obtaining proximity and comfort in addition to values they hold of themselves as a component within a relationship (Bowlby, 1973). These features appear to be fully developed within an infant's personality at three years of age, enabling them to understand the world and imminent interactions with others (Schore, 2000). Bowlby (1969) asserted that the primary attachment figure acts as a prototype for the child's future relationships through the internal working model (IWM) (Pietromonaco & Barrett, 2000). Therefore, the attachment style one develops is compatible/fitting to the style of nurturing they received (Bowlby, 1982).

As detailed above, an attachment figure's level of awareness of their infants' distress is a significant component shaping the style of attachment that infant will acquire (Weinfield, Sroufe, Egelan & Carlson, 1999). If the caregiver is responsive to the needs of their infant, then a secure attachment will emerge. This is therefore correlated with a confident self-image and positive views of others, including the ability to act independently, maintain intimate relationships and robust coping strategies. However, a caregiver who is unresponsive to their infant's distress can

result in this distress escalating in the hope that these needs will be met (insecure-anxious attachment). This can also be described as hyperactivation of emotion regulation strategies (Mikulincer, Shaver & Pereg, 2003). In contrast, an infant learns to disable their attachment system, linking to a dismissive approach where they avoid close relationships (insecure avoidant) (Shaver, Belsky & Brennan, 2000; Shaver & Mikulincer, 2002), which can be described as deactivating strategies of emotion regulation (Mikulincer et al., 2003).

According to Thompson (1994) "Emotion regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (p. 27-8). With that said, attachment theory (Bowlby, 1969, 1973, 1980, 1982) states that an essential goal for an infant is to maintain proximity to their caregiver. Therefore, adhering to Thompson's position would see children having to regulate their emotions toward achieving this goal. Further more, the sense of attachment security that is provided by the interactions with available attachment figures allows for emotion regulation strategies that are constructive. For example, when an interaction occurs with an individual (usually caregiver) who is responsive and accessible emotionally, a child learns that the acknowledgment and display of emotions is essential in the restoration of emotional balance. This includes accepting and identifying the effectiveness of expressing and exploring how one feels. Avoidant individuals isolate their emotions away from thoughts and behaviour. This leads to portraying pretence of security and equanimity. However, this unresolved stress prevents them from having the capabilities to manage stressful life events (Mikulincer, & Shaver, 2012). In contrast, infants scoring high on attachment anxiety, the regulating of emotions means amplifying and exaggerating worries, which is inline with their attachment-system (hyperactivation). In addition, attachment anxiety is connected with

impulsive behaviour that is demanding and sometimes violent toward partners or outbursts of anger that are socially destructive (Mikulincer & Shaver, 2010).

Bowlby (1944) referred to the hyperactivating and deactivating strategies of the attachment system to as ‘maternal deprivation’ (e.g. separation/loss of mother, poor or unreliable care from primary care givers). Other researchers have also produced evidence stating that attachment insecurities, negative internal working models of self and others as a result of deterring experiences with inaccessible and rejecting attachment figures, leaves individuals vulnerable to psychological disorders (Mikulincer & Shaver, 2010). Bowlby (1980) advocated that the deficit of attachment security during infancy through to adolescence plays an important role in the vulnerability to depression. This deficit may be the result of recurrent failure to develop a secure relationship with an attachment figure or the death of a primary caregiver, which promotes the development of poor self-representations. Furthermore, an ‘abandoned’ child will be prone to feelings of powerlessness and helplessness in an effort to retain presence of a negligible caregiver or obtain love, support and appreciation from a caregiver that is consistently unresponsive or rejecting (Mikulincer & Shaver, 2010). Green (1986) termed these infant thoughts and feelings as ‘the dead mother complex’, as a result of the emotional unavailability to her. Parallel to other author’s models of depression (e.g. Beck, 1976) Bowlby (1980) considered that these childhood feelings and beliefs stimulated symptoms of depression, particularly when those who are insecurely attached, experience further difficulties, trauma and loss.

The attachment insecurities that result from the unavailability of an attachment figure can also result in anxiety disorders (Bowlby, 1973). This is due to failings of the attachment system in protecting the child whilst exploring their world. For those who are insecurely attached, the world is hostile, full of danger without a secure base to return to. Additionally, individuals who

are anxious are uncertain of their capacity to manage danger alone and are persistently cautious of impending threats. These feelings and core beliefs can amplify the responses given to perceived threat, which encourages them to employ avoidance as a coping strategy. This approach is common in the majority of anxiety disorders (American Psychiatric Association, 2003).

Harris, Brown and Bifulco (1990) support Bowlby's concepts that enduring consequences of discouraging attachment related experiences lead to psychopathology in adulthood. They found that persistent separation or the death of the primary caregiver in infancy increased susceptibility to depression in adulthood. The correlation between traumatic attachment experiences in early childhood and later depression appears stronger in those who had insecure working models prior to the loss (Cummings & Cicchetti, 1990) and those who received insufficient care and support subsequent to the trauma (Mikulincer & Shaver, 2010). It has been suggested that poor caregiving during infancy or extended separation from parents (i.e. divorce) are correlated with greater risk for panic disorder or agoraphobia in later life as originally proposed by Bowlby (Faravelli, Webb, Ambronetti, Fonnesu, & Sesarego, 1985; Brown & Harris, 1993; Mikulincer & Shaver, 2010). In multiple controlled studies, adults with anxiety or depression defined their caregivers as unavailable, rejecting and unsupportive (Gotlib, Mount, Cordy, & Whiffen, 1988; Cassidy, 1994; Enns, Cox, & Clara, 2002; Mikulincer & Shaver, 2010). However, some of this research had a low participant response rate and are consequently not generalisable. In addition, it can be argued that adults experiencing depression are likely to have cognitive bias to recall depressive memories (Lyubomirsky, Caldwell and Nolen-Hoeksema, 1998) thus the reliability of retrospective accounting is questionable.

Mikulincer and Shaver (2010) conducted a meta-analysis and found over 100 studies in clinical and non-clinical samples that have researched the relationship between attachment in adulthood and symptoms of anxiety and the severity of depression using self-report tools including the Spielberger's State–Trait Anxiety Inventory (STAI; Spielberger, 2010) and Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996). Attachment security to caregiver, peers, close relationships and secure states of mind (as assessed using the Adult Attachment Interview; AAI) are consistently correlated with anxiety and depression. Notably, the majority of studies included in the meta-analysis were cross-sectional; findings may imply that attachment insecurities precipitate symptoms of anxiety and depression or that these conditions corrode attachment security. While the latter is ambiguous, research exercising prospective designs has established that attachment insecurities expect depression to increase over time (one month to two years).

Evidently attachment insecurities play a significant role in the development of psychopathology. The evidence is attuned with the theoretical notion that attachment security acts as a resource of resilience sustaining ones mental health and reducing the probability of psychological disorders even in the face of stress and trauma. Dissimilarly, insecure attachment styles are pathogenic states that impact the possibility of psychopathology. Despite much of the support for these findings being correlational and open to interpretation, numerous studies have found associations between early attachment orientations and subsequent vulnerability to anxiety and depression. Therefore, it is not unreasonable to believe that insecure attachment predisposes individuals to the development of some form of psychological distress. It is suggested that this is likely to have an impact on the attachment of their infants.

Predominantly, Bowlby was concerned with understanding the complexities of infant-caregiver relationships. However, he believed that attachment was the foundation of human experience from the beginning until the end. Researchers only began to consider attachment processes occurring in adulthood in the 1980's. Two separate researchers following different methods investigated attachment in adulthood. Main concentrated on the prospect that an adult's interpretation of their relationship with their caregiver affected their own parenting behaviour which then further impacted the attachment of the caregivers' own children. Main and his colleagues interviewed caregivers surrounding their family relationships in childhood and explored features of the interview transcripts that could be scored to conjecture their infants foretold attachment classifications from Ainsworth's Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978). Successive predictive studies using the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) validated the association between the assessments of infant attachment classifications and their caregiver's interview codes. This has since been repeated numerous times (van Ijzendoom, 1995). Caregivers with dismissing attachment related memories, had infants who were categorised as 'avoidant' in the strange situation. Infants who were categorised as 'anxious' had caregivers that were anxiously preoccupied and had difficulties associated with attachment. Caregivers that were free and autonomous in relation to attachment, had infants that were categorised as 'secure' in the strange situation. Later, an additional pattern of infant attachment was identified characterised as 'disorganised'. This found caregivers having unresolved trauma or loss in relation to their attachment related memories (Bartholomew & Shaver, 1998).

Hazan and Shaver (1987) investigated an alternative avenue of attachment research.

They first considered adult attachment in relation to romantic relationships, stating that the emotional bond developed between romantic partners operates from the same system (the attachment behavioural system) that precipitates the emotional bond between infants and attachment figures. Hazan and Shaver (1987) indicated that both types of relationships (infants and attachment figures and adult romantic partners) share the same qualities: (a) safety when the other is within proximity and is responsive; (b) participation in intimate, bodily contact; (c) insecurity when one cannot access the other; (d) engaging in 'baby talk'; (e) sharing new information with one another; (f) demonstrating a reciprocal preoccupation with each other. On account of these parallels, it was contended (Hazan and Shaver, 1987) that adult romantic partnerships, are attachment relationships like that of infant caregiver relationships and the love shared between the partners belongs to the attachment behavioural system, in addition to the motivational system that precipitates caregiving and sexuality (Fraley & Shaver, 2000). They had previously studied adult loneliness and followed up on the research of Weiss's (1982) who indicated an association between chronic loneliness and insecure attachment. Stating that the majority of young adults were ineffectively pursuing a secure romantic attachment and that the choice of romantic partner may be an extension of earlier attachment experiences. Hazan and Shaver formulated a self-report measure specifically for adults that was grounded in Ainsworth's three categories of childhood attachment: secure, avoidant and anxious. The questionnaire asked respondents to consider the most significant romantic relationships they've had and choose the description that was the most suitable in accordance with the three attachment categories. Following studies using this measure and several variations have found correlations to personality variables, behaviours and experiences within close relationships. (Shaver & Hazan, 1993; Shaver & Clark, 1994). Some studies have compared the measure with reflective reports of

an individual's experiences in childhood with caregivers but the majority of research has concentrated on how attachment patterns impact adult relationships and individual adjustment (Bartholomew & Shaver, 1998).

Bartholomew (1990) examined both the Adult Attachment Interview (AAI) and Hazan and Shaver's self-report attachment questionnaire recognising both measures assess attachment in different ways. She found that individuals who were identified as dismissing avoidant by the Adult Attachment Interview (AAI) rebuffed experiences of distress and minimised the importance of their attachment needs. However, those identified as avoidant on Hazan and Shaver's self report questionnaire conveyed fears around closeness to others and increased levels of subjective distress (Bartholomew & Shaver, 1998). Bartholomew (1990) contended that two clear modes of avoidance were apparent. One deriving from defensive patterns of self-reliance (identified as "dismissing") and the second motivated by fears of possible rejection from others (identified as "fearful"). She also observed that the two methods focused on separate areas and separate analysis of adult attachment. The Adult Attachment Interview (AAI) focuses on the reflections of the relationship between parent and child and the subtleties of internal working models (IWM's), which are exposed implicitly through respondents talking about their childhood relationships. Though the Adult Attachment Interview (AAI) is not constructed on the basis that respondents are aware of these subtleties (Bartholomew & Shaver, 1998). In comparison, the self-report measure is focused around recent romantic relationships that include the feelings and behaviours in these close relationships. Respondents are aware of this and can provide precise information. Bartholomew offered an expanded model of adult attachment that combined elements from both the Adult Attachment Interview (AAI) and the self-report questionnaire. This model organised Bowlby's (1973) concept of internal working models (IWM's) using a

four-category categorisation scheme (Bartholomew, 1990; Bartholomew & Horowitz, 1991; see Figure 1). Four prototypical attachment styles are classified based on two dimensions: level of confidence in ones model of self and level of confidence in ones model of others. A positive model of self refers to the level in which an individual has internalised their sense of self-worth over and above feelings of anxiousness or uncertainty of how lovable they feel (Bartholomew & Horowitz, 1991). Therefore, the model of self is linked with the level of anxiety and reliance on the approval of others in close relationships. The confidence of the others model specifies the level in which others are largely anticipated to provide support and availability. Thus the other model is correlated with the affinity to pursue or avoid closeness in relationships (Bartholomew & Horowitz, 1991). A secure attachment in adulthood is depicted by the combination of a positive model of self and a positive model of others. Individuals characterised as secure internalise their sense of self worth and feel comfortable with closeness in relationships. A negative model of self with a positive model of others describes preoccupied attachment. These individuals anxiously pursue others to obtain acceptance and validation. Persistent in the belief that if they could get others to respond appropriately toward them they could accomplish security. Fearful attachment is categorised by a negative model of self and others. Like preoccupied individuals, fearfully attached individuals, depend heavily on the acceptance and affirmation of others acceptance. However, their negative expectations, lead them to evade closeness to avoid the hurt caused from loss or rejection. Finally, a positive model of self and a negative model of others illustrate the dismissing style of attachment. They avoid closeness due to negative expectations. However, their sense of self worth is maintained by defensively rejecting the importance of close relationships. The secure, preoccupied and dismissing styles of this model are theoretically comparable to the Adult Attachment Interview (AAI) classifications

and secure, preoccupied and fearful are comparable to Hazan and Shaver's secure, anxious-ambivalent and avoidant categories.

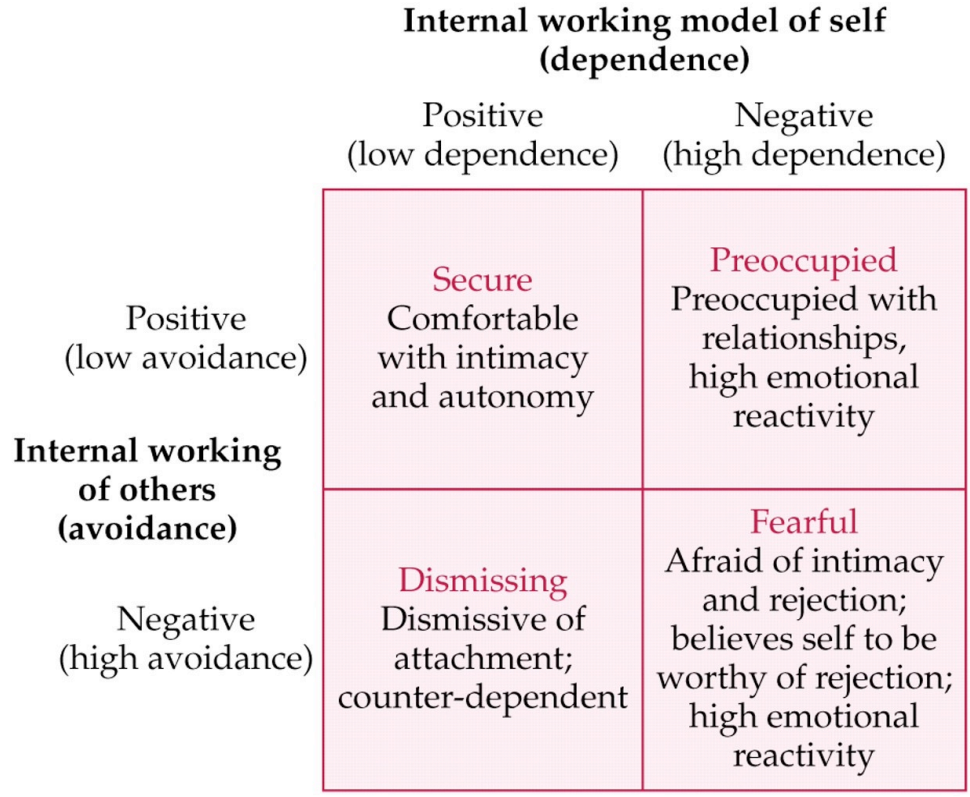

Figure 1. Bartholomew's four-category model of Attachment (Bartholomew & Horowitz, 1991)

The empirical research to support attachment theory and its development is unequivocal. Fraley and Shaver (1998) repeated the principles of Ainsworth's strange situation with adults and found outcomes mimicked that of the original completed with infants representing the validity amongst the theory. Its principles embody child development and as Bowlby deduced, it is the foundation of human experience from the beginning until the end. As a result, the care received from birth remains rooted in our behavioural and emotional composition. Some researchers have focused their efforts on the stability of attachment and whether certain events, environments or

processes can lead to changes in ones attachment orientation (Baldwin & Fehr, 1995; Hamilton; 2000). The therapeutic process has been found to be an environment that can facilitate this change (Travis, Binder, Bliwise, & Horne-Moyer, 2001; Levy, Ehrenthal, Yeomans, & Caligor, 2014).

2.4. Attachment In The Therapeutic Environment

Over several decades the idea of the therapeutic relationship (Freud, 1912; Greenson, 1967; Sterba, 1934; Zetzel, 1956) has become the foundation amongst many models within psychological therapies. Bowlby (1988) claimed that psychotherapy included essential elements of an attachment relationship as it is thought to represent the way a client relates with their significant others and friends (Levy et al., 2014). From a psychoanalytical viewpoint, Freud (1912) originally referred to the relationship as positive transference where the client believes in the therapist's interpretations. It (positive transference) contains distortions of the original relationship that the client is projecting onto the therapist and requires analysis by the therapist. Gitleson (1962), Horwitz (1974) and Bowlby (1988) later proposed that the client acquires the ability to develop a positive relationship where the client's needs are met as a result of the therapist and the process of therapy. The qualities within this relationship are different from those with early caregivers, representing a new era of relationship. The therapist's objective is to sustain positive stance toward the client that is grounded in reality in order to afford the client the opportunity to reflect on the differences amongst the real and inaccurate properties of the relationship (Frieswyk et al., 1994).

According to the humanistic theorist Rogers (1957), the therapist's competence to embody empathy, congruence and unconditional acceptance (unconditional positive regard;

UPR) were fundamental conditions for enhancing the therapeutic relationship and outcome. However, his suggestions overlook the prospect of differences amongst the clients' willingness to engage in the proposed relationship. It is assumed that the clients' response will mirror the behaviour of the therapist providing the therapist possesses the appropriate attitude (Horvath & Luborsky, 1993). Throughout recent years, numerous studies have explored the influence of the core conditions on the therapeutic relationship. Early research significantly correlated with the primary hypotheses: Therapists were more successful with clients when offering elevated levels of empathy, congruence and UPR than those offering reduced levels (Barrett-Lennard, 1986; Rogers, Gendlin, Kiesler, & Truax, 1967). Furthermore, a large quantity of the findings reveal that it is in fact how empathic the client interprets the therapist to be, as opposed to the actual behaviour demonstrated by the therapist that produced the strongest relationship with outcome (Horvath & Luborsky, 1993).

Advances in research in the 1980's intriguingly found that various therapies consistently produced comparable therapeutic improvements (Krupnick, Sotsky, Simmons, Moyer, Elkin, & Watkins, 2014; Luborsky, Singer, & Luborsky, 1975; Stiles, Shapiro, & Elliott, 1986; Smith & Glass, 1977), suggesting that the methodological weaknesses among collective studies (Luborsky, 1990; Shadish & Sweeney, 1991) and the possibility of systematic variances across therapeutic approaches (that may be apparent beneath the surface of these widespread inferences; Beutler, 1979) are a result of universal variables present in all therapeutic modalities that result in client enhancement. Bordin (1994) speculated that the relationship itself increases the effectiveness of therapy (Bordin, 1994). That is not to say that a positive relationship 'heals' the client independently but more that it is the foundation that makes change a possibility for the client (Bordin, 1980). Additionally, his interpretations provide a different perspective to the

conventional divided view of technical factors and process factors in therapy. Bordin (1994) suggested these two factors are reliant upon one another rather than acting as separate entities and the progression within one aspect promotes within the other (Bordin, 1994). The collaborative nature of the model suggests that the client attaches to the therapist partially as a result of their evaluation of the strength and significance of the interventions offered. Therefore conflicting with the proposal presented by Rogers where a client's response is instinctive to the positive manner of the therapist (Horvath & Luborsky, 1993).

Through the evolution of research, the therapeutic relationship has unmistakeably transpired to be a significant variable within the therapeutic process in order to facilitate change (Ackerman & Hilsenroth, 2003; Orlinsky, Grawe, & Parks, 1994; Frieswyk et al., 1986; Freud, 1912; Martin, Garske, & Davis, 2000; Hilliard, Henry, & Strupp, 2000; Barber et al., 1999; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Blatt, Sanislow, Zuroff, & Pilkonis,, 1996; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Frieswyk et al., 1986). Bowlby (1988) contended that the therapeutic relationship facilitates a client to shift from an insecure pattern of attachment to secure, in addition to improving attachment status (Diamond, Stovall-McClough, Clarkin & Levy, 2003; Daniel, 2006). According to Bowlby (1988) the therapist's role is to behave as an attachment figure by offering a secure base to assist in the client's exploration of previous attachment experiences and therefore provide compassionate emotional encounters to diminish insecure internal working model's (IWM's) (Bucci et al., 2015).

The ability of therapists to represent an effective attachment figure and establish an effective therapeutic relationship is likely to be guided by their own style of attachment. A systemic review was completed (Degnan, Seymour-Hyde, Harris, & Berry, 2014) examining the

effect of therapist attachment on therapeutic alliance and outcome. They found some support for the attachment style of the therapist and interactions between client and therapist attachment styles impact the outcome of therapy and the therapeutic relationship, concluding that there is appropriate evidence to suggest that therapists should consider how their attachment style impacts upon the therapeutic relationship (Degnan et. al., 2014).

Previous research has primarily focused on client variables. For example, it has been suggested that client variables other than attachment, such as their existing social relationships or motivation for therapy, have an influence on the therapeutic relationship and the therapeutic outcome (Horvath, 1994). It was argued that the client's capacity to form a positive relationship underpinned the alliance. Thus, an attribute that a client brings to treatment is their ability to configure an alliance (Black, Hardy, Turpin & Parry, 2005). Conversely, it has been argued that a therapists' ability to form an alliance is of equal importance. However, does this matter as long as the relationship works to facilitate the client's growth? Beutler (1997) proposed therapist' variables should be considered to the same degree as that of clients. Much of the research that has since focused on therapist factors has concentrated on a therapist's capacity to adhere to treatment protocol or competencies of the professional (e.g. Kivlighan, Patton, & Foote, 1998). In addition, characteristics of the therapist have been a secondary consideration in literature concentrating on alliance/outcome resulting in a small sample of therapist participants and generalisation of findings is ambiguous (Elkin, 1999). Such limitations make the current research eminent, as the emphasis is placed on the therapist in addition to the client. Despite the limitations, research in this area has suggested that individual characteristics (including their ability to establish a sincere and supportive environment) are significant elements in the

formation of the therapeutic relationship (e.g. Roth & Fonagy, 2013; Orlinsky, Grawe, & Parks, 1994). Thus a focus on therapist attachment within the therapeutic environment is required to gain further understanding of any impact from this variable. Such is the aim of the current study.

Bowlby (1988) asserts that when people are scared, tired, or unwell they exhibit attachment behaviours designed to provoke caregiving behaviours in those around them. The type of care provided is determined by the attachment styles of both the individual in distress and the caregiver. It could be contended that a definitive attribute of therapy is that it transpires when a client is vulnerable. Thus both the client and therapist's (caregiver) attachment styles potentially influence the development of the therapeutic alliance. For example, Hardy, Stiles, Barkham, & Startup (1998), found that the attachment style of a client is associated with the different responses a therapist makes at important moments in therapy. Furthermore, Rubino, Barker, Roth and Fearon (2000), explored the therapist's approach to resolving ruptures within the relationship in addition to the therapist's and client's attachment style. They found anxiously attached therapists were less empathic in their responses, specifically with fearful and securely attached clients (Rubino et al., 2000). These findings contribute to how the measurement of attachment within the therapeutic environment can facilitate professionals in better assisting clients. If the interaction of attachment styles contribute toward the variance in predicting therapeutic alliance and outcomes, it may reduce client ruptures.

Similar findings have suggested that elements related to attachment hold significance. For example Henry, Schacht and Strupp (1990) and Henry and Strupp (1994) found that therapists' introjects (an unconscious process where one adopts the characteristics of another) had a favourable influence on both the process of their sessions with the client and the relationship. Poor alliance and problems in therapeutic processes were more likely to occur with therapists

exhibiting antagonistic introjects. Dunkle and Friedlander (1996) explored the personal attributes and experience of therapists in training, finding relationships between particular attributes (e.g. comfort with closeness) and the quality of the alliance as rated by the client. Peschken and Johnson (1997) found that the amount of trust a therapist held toward their client (a factor within secure attachment) was associated with the level of trust a client had in the therapist. Ackerman and Hilsenroth (2003) reviewed features of the therapist within the alliance finding a positive association between several therapist characteristics, for example, flexibility, warmth, honesty, openness, trust, consideration and the alliance. The majority of these attributes are used when describing traits of secure attachment. A review conducted by Meyer and Pilkonis (2001), evaluated studies of the role of attachment style in psychotherapy. They found that it is desirable for a therapist to hold a secure attachment in order to manage problems in therapy. However, it is of equal importance for the alliance that a therapist is not anxiously attached. Therapists with a secure or avoidant attachment seem to perform better. This is likely to be due to their ability to distance themselves. In addition, they found that having the opposing attachment style to a client is of secondary significance to secure attachment. The interaction of client and therapist attachment styles as part of the current research aims to identify whether opposing styles of attachment do in fact impact the therapeutic alliance and severity of psychological distress.

Black et al. (2005) explored the association between therapists' self-reported attachment styles, quality of the alliance and problems reported in therapy. They found that the attachment styles reported by therapists have an impact on the perceived quality of the relationship and the therapist's perception of problems in therapy. Specifically, anxious attachment was significantly positively correlated with the amount of problems therapists reported in therapy and significantly

negatively correlated with a good working alliance. In addition, they found securely attached therapists reported a better alliance with their clients.

Dozier and Tyrrell (1998) report that models of secure attachment handle attachment related issues in a flexible, open and non-defensive manner and therefore likely to approach others in a receptive, open and collaborative way. Prospectively, assists in generating a positive therapeutic relationship. Moreover, this study found that therapists who reported increased levels of insecure attachment were a significant predictor of a poor alliance as reported by them. Dozier, Cue, and Barnett, (1994) used detailed interviews (using the adult attachment interview) to obtain data, hierarchical regression of therapist security and client preoccupation on type of intervention, in addition to further correlating client preoccupation and intervention type independently for therapists' who scored above and below the median for security. They found that therapists with insecure patterns of attachment intervened further with anxiously attached clients by failing to challenge the clients' interpersonal strategies. Secure therapists intervened at a deeper level with avoidant clients by challenging the clients working model. They determined that secure therapists have the ability to challenge clients' interpersonal strategies whereas insecure therapists failed to accomplish this. It is possible that the environment provided by a securely attached therapist are what materialise into facilitating a positive therapeutic alliance (Dozier, Cue & Barnett, 1994).

Paradoxically, the environment offered by a therapist may be irrelevant if it is in fact the client's attachment or opinion of the therapist that has the overall impact (Fonagy et al., 2002; Mallinckrodt, 2000; Mallinckrodt, 2010; Mallinckrodt, Daly & Wang, 2009; Sable, 1997; Slade, 1999; Szajnberg & Crittenden, 1997). Mallinckrodt, Gantt and Cobel (1995) developed a client attachment to therapist scale (CATS) consisting of three domains; secure, avoidant-fearful and

preoccupied-merger. Clients within the secure dimension view their therapist as someone who is emotionally available, sensitive, responsive and exerts a comforting presence. Clients within the avoidant-fearful dimension view their therapist as disapproving and rejecting if dissatisfied. These clients felt threatened in sessions and resistant with regard to self-disclosure. The preoccupied-merger refers to clients who want more contact with their therapist to the point of impeding boundaries and longed to be the 'favourite' of all their therapist's clients. These areas were assessed by the self-report client attachment to therapist scale (CATS; Mallinckrodt et al., 1995). Mallinckrodt et al. (1995) reported that during the development of the client attachment to therapist scale, only the preoccupied–merger significantly correlated with the depend subscale (one of three subscales) of the Adult Attachment Interview (AAI; Collins & Read, 1990).

Mallinckrodt, Porter and Kivlighan, (2005) explored the relationship between the romantic attachment of adult clients and attachment to their therapist. They hypothesised that the attachment held with a romantic partner would be mirrored in the therapeutic environment. They found that both anxious and avoidant attachments correlated with Avoidant–Fearful attachment to therapists. Interestingly, two differing forms of attachment insecurity affected client attachment to therapist in a similar way. Their findings propose that clients with attachment insecurities are less inclined to self-disclose/explore their difficulties and work together to decipher goals of therapy than those who have the ability to develop a secure attachment with their therapist. In comparison, clients who have a strong premise of either avoidance or anxiety with significant others are inclined to display avoidance within the therapeutic environment. This too involves the propensity to mistrust their therapist, hesitation to self-disclose and adverse opinions around therapy itself. In addition, a client with an avoidant attachment to their therapist experiences sessions as turbulent and superficial. These findings are also consistent with further

studies that associated difficulties in clients' generalised attachment patterns with a weak alliance (e.g., Eames & Roth, 2000; Kanninen, Salo, & Punamaki, 2000; Kivlighan, Patton, & Foote, 1998; Mallinckrodt et al., 1995; Satterfield & Lyddon, 1995). It is possible that dysfunctional internal working models of self and others, impact on a clients' opinions and expectations of their therapist and how their therapist will view the client. This could be construed as transference (Kivlighan, 2002; Szajnberg & Crittenden, 1997).

Mallinckrodt (2010) illustrated that five of the basic features of a secure attachment relationship with a caregiver in infancy as recognised by Mikulincer and Shaver (2010) can be exhibited as components that are evident amongst a secure attachment with ones therapist. In addition, anxiously attached clients are more inclined to amplify their efforts to ascertain the five features, whereas avoidant clients are more likely to resist the therapists' attempt to establish these features along with minimising their importance. For example, the 14 items of the client attachment to therapist secure subscale targets the measurement of opinions toward the therapist as a secure base for exploration, a comforting presence and as an accessible, dependable and sensitive figure. The client attachment to therapist avoidant subscale targets the measurement of clients' resistance toward the development of a secure base, or closeness within the therapeutic relationship. The 10 items of the client attachment to therapist preoccupied targets the measurement of clients' insecure propensities requiring close proximity, a wish to distort professional boundaries and a fixation surrounding the therapists' additional clients. The client attachment to therapist scale was established independently and prior to the formulation of Mikulincer and Shaver's (2010) formulation. Yet, the three subscales appear to manifest universal themes of primary secure and secondary anxious or avoidant attachment.

A client who exhibited a secure attachment to their therapist was also found to be highly correlated with a strong therapeutic alliance (Mallinckrodt, Porter & Kivlighan, 2005). Therefore, with the assumption that the therapist will typically be accessible, it could be suggested that attachment security within the therapeutic environment, may enable clients to manage the difficulties of brief ruptures amongst the alliance (Kanninen et al., 2000; Safran & Muran, 2000). Research that examined clients who had been in therapy an average of 10 months found that clients reporting a secure attachment to their therapist (assessed using the client attachment to therapist scale), was linked to negative client transference as rated by therapists (Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003). Following the analysis of these results, Woodhouse et al., (2003) considered the prospect that a client is provided with a secure base as a result of their secure attachment to their therapist, which in turn presents the client with the opportunity to examine any negative transference especially those in long term therapy.

Mallinckrodt and Jeong (2015) completed a meta-analysis of research between 1995-2013. All the studies included within the analysis had used the client attachment to therapist scale (CATS) with clients accessing therapeutic services. The subscales of the client attachment to therapist scale (Secure, Preoccupied, Avoidant) were examined in connection with client global attachment style (pre therapy), client-rated alliance, or both. In reference to pre-therapy adult attachment, they found that the secure subscale was negatively correlated with client avoidance and anxiety. The avoidant subscale was positively correlated with client attachment anxiety and avoidance. Only client attachment anxiety was significantly correlated with the preoccupied subscale. The perception of a stronger therapeutic alliance was associated with a more secure attachment and with less avoidance. With regards to the therapeutic alliance, a secure client attachment to therapist was positively correlated. Avoidant client attachment to

therapist was negatively correlated and a preoccupied client attachment to therapist exhibited no significant relationship with the alliance.

The argument surrounding whether the therapist can be an attachment figure appears to be dependent on how the client perceives the therapist to be during their sessions. The aim of this study is to identify whether specific attachment styles interact to result in better relationships and reduce symptom severity. A similar study by Bucci, Seymour-Hyde, Harris and Berry (2015) examined the degree to which client and therapist self-reported attachment styles correlated with the therapeutic relationship. They analysed thirty client-therapist dyads that were recruited from primary care psychological services. Anxiety, depression, attachment style and working alliance were recorded from one time point using self-report measures. They found the attachment security of client and therapist was not individually related to the therapeutic relationship. Yet, they did find a significant correlation between therapist's who held an insecure attachment style and the therapeutic relationship of more symptomatic clients. The researchers concluded with an indication that the association between alliance and therapist attachment style is complex and suggested that the complicated nature of the client's symptomatology together with the interaction of client–therapist attachment styles, impacts the therapeutic relationship.

From the research reviewed, it can be assumed that attachment is engrained in everyone and each individual is regulated by their attachment needs. Therefore, in a therapeutic setting attachment will have a presence. Furthermore, the research presented recognises that the therapeutic relationship is significant for change to occur. What remains to be clearly identified is how the attachment from both the client and the therapist correlate to impact both the relationship and therapeutic change.

2.5. The Present Study

The purpose of this study is to support existing research that attachment plays a significant role within the therapeutic environment. It aims to determine which attachment style interactions generate enhanced therapeutic outcomes and relationships compared with other interactions. This research differs from other attachment research of a similar nature by measuring at two-time points, focusing on short-term therapy and using different measures for the therapeutic alliance. The aim is to identify whether the therapeutic alliance is predicted by the interaction between therapist and client attachment and if the interaction between client and therapist attachment explains more variance in the outcomes of therapy (change in anxiety and depression score) than perceived alliance. It builds on previous research by uniting the attachment of both parties in to one variable to determine the impact of this on both the therapeutic relationship and therapeutic outcome as opposed to determining the impact from the perspective of one or the other.

From previous research we can hypothesise that:

- Securely attached therapists will have a stronger therapeutic alliance with clients.
- Securely attached therapists will provide the greatest change in symptom severity.

However, for the purpose of this new research the following hypotheses will be tested:

1. The interaction between therapist attachment and client attachment will have a statistically significant effect on symptom severity in clients.

2. The interaction between therapist attachment and client attachment will be a statistically significant predictor of the therapeutic alliance.

In addition to the main hypothesis, this research will attempt to answer the following questions:

1. Which attachment style combinations provide better therapeutic relationships?

2. Which attachment style combinations provide better therapeutic outcomes?

In answering these questions, it is anticipated that this research will support existing literature while boasting new findings.

Chapter 3 – Empirical Study

3.1. Abstract

Objective: Many researchers have authenticated the relationship between the therapeutic alliance and therapeutic outcomes through individual studies or meta-analysis. However, existing research of how the client and therapist contribute to this relationship is ambiguous, with a tendency to focus on client characteristics. Attachment theory provides a platform for exploration into the impact that both the client and therapist have upon the therapeutic relationship and therapeutic outcomes. The purpose of this research is to identify whether the attachment orientation of the client and therapist interact during the therapeutic process and influence the therapeutic alliance and outcome of therapy.

Method: This quantitative study recruited 38 client and therapist participants from private therapy services to complete a measure of attachment at session one of therapy and a measure for the therapeutic alliance at session six. Clients also completed measures of anxiety and depression at for one of therapy and session six of therapy. Regression analysis was used to determine an interaction between client and therapist attachment styles and the impact of this on the alliance and change in symptom severity.

Results: Clients' perceived alliance was the significant contributing factor to changes in the severity of depression and anxiety. Therapists who exhibited a secure attachment had stronger therapeutic relationships and clients displayed a greater reduction in symptom severity when their therapist was securely attached. Client and therapist alliance raw scores explained 15.3% of the variance for changes in depression. This variance increased to 30.7% for changes in

depression when a single indicator of attachment was introduced. The interaction of client and therapist attachment styles explained no variation with therapeutic outcomes.
Conclusion: These findings support previous research and new areas worth investigation are identified. 68.2% of the variance is shared by other variables not included in the regression analysis, which presents a gap for future research to explore.

3.2. Introduction

The therapeutic relationship is a widely researched subject area and is the basis for the majority of psychological therapies (Levy et al., 2014; Luborsky, 1984; Rogers, 1957). Many definitions have come to light (Greenson, 1971; Safran & Muran, 2000). However, a recurring theme across them all is the presence and contribution of both the client and the therapist (Elvins & Green, 2008). As research has grown, an understanding of the relationship has revealed its significance on influencing the reduction of client distress (Bordin, 1980). This finding is the result of exploring the relationship from both client and therapist perspectives (Norcross, 2002). Findings collectively affirm that a clients' perceived alliance is the significant contributing factor in the reduction of client distress (Horvath & Bedi, 2002; Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Importance is also placed on examining other variables that impact both the therapeutic relationship and therapeutic outcomes. Some of which include personality traits and demographic factors. However, the most significant findings are those involving interpersonal features (Norcross, 2002).

Bowlby's (1969) theory of attachment is a prominent theoretical framework that facilitates the understanding of personality, social development and close relationships (Cassidy & Shaver, 2010). Therefore it is undoubtedly a theory of interpersonal interactions. It is

considered to be a foundational framework for understanding the interplay between client and therapist within the therapeutic environment (Bowlby, 1969). Attachment theory spans across the lifespan and argues that human beings are instinctively driven to bond with others (Baumeister & Leary, 1995). This begins in infancy when the proximity of one's caregivers is sought. The significance is placed on their availability. If the attachment figure is available, security and confidence are felt. However. If the attachment figure is unavailable, they are likely to feel anxious and distressed. The behaviour continues until proximity is achieved or until they give up (Bowlby, 1969). The relationship between an infant and their primary caregiver leads to the development of internal working models (IWM's; Bartholomew, 1990; Bartholomew & Horowitz, 1991; Bowlby, 1969), which encompass mental representations used to understand one's self, the world, and others. This internal working model (IWM) and availability of caregivers contribute to the style of attachment acquired by an infant (Weinfield, Sroufe, Egelan & Carlson, 1999). When a caregiver responds to the needs of their infant, then a secure attachment will emerge. Thus correlating with a confident self-image and a positive view of others. However, a caregiver responding inconsistently to their infants' needs lead to an anxious style of attachment (Gleeson & Fitzgerald, 2014) and an insecure self-image and positive view of others. Finally, caregivers who are repeatedly unresponsive results in an avoidant style of attachment (Bowlby, 1969) and a negative view of self and others.

Primarily research around attachment revolved around children. However, several researchers expanded exploration to include adolescents and adults (Fraley & Shaver, 2000; George, Kaplan, & Main, 1985; Hazan and Shaver, 1987; Weiss, 1982). Methods of measuring adult attachment have now been established and can be divided into quantitative measures (questionnaires e.g. Experience in Close Relationship Scale-relationship structures; ECR; Fraley,

Heffernan, Vicary, & Brumbaugh, 2011) and qualitative measures (Adult Attachment Interview; AAI; George, Kaplan, & Main, 1985). Through these measures, attachment research in adults soared and much of the research has identified a correlation between unavailable caregivers in childhood and psychopathology (Fraley, 2007; Mikulincer & Shaver, 2010).

Bowlby (1980) believed that insufficient attachment security throughout childhood and adolescence precipitates one's susceptibility to depression. This deficiency could be the result of persistent failings in the acquisition of a secure relationship with an attachment figure and would stimulate poor self-representations (Fraley, 2007). Research has also found individuals who had insecure working models prior to a childhood trauma (Cummings & Cicchetti, 1990) and those who received insufficient care and support subsequent to the trauma (Mikulincer & Shaver, 2010) strongly correlated with depression in adulthood.

Attachment theory can be used to understand key features of the therapeutic environment including underlying causes for their attendance to therapy and the therapeutic relationship itself. Previous research has focused on the client's attachment to their therapist, attachment focused therapy and the therapist as an attachment figure amongst others. Therefore there is sufficient support affirming the presence of attachment within the therapeutic environment thus advocating the inclusion of attachment theory as a predictor of the therapeutic alliance and client outcomes. This research will focus on the interplay between client and therapist attachment styles to determine if one combination is more favourable than that of another.

3.3. Design

A longitudinal cohort design was applied, allowing observations of the same variables to be compared on two occasions to distinguish any relationship (Farrington, 1991). The independent variable within the study is attachment, and the dependent variable is change in depression, change in anxiety and the therapeutic relationship. Quantitative data was collected and correlated as these methods are deemed the most suitable when determining differences between groups (Mujis, 2010).

3.4. Participants

3.4.1. Psychologists

1938 psychologists were contacted via email. Contact details were obtained from the 'Directory of Chartered Psychologists' under the 'find a psychologist' section on the British Psychological Society website (http://www.bps.org.uk/bpslegacy/dcp). Psychologists (n=70) were contacted via email from searching 'psychologist' under the 'find a therapist' section on the EMDR (Eye Movement Desensitisation and Reprocessing) Association website. Of the 2008 can that were contacted, 86 agreed to take part in the study, but only 38 returned the completed packs. This met the criteria as defined by Cohen (1992) that more than 30 subjects were sufficient to achieve a decent level of statistical significance for multiple regression models. Demographic details for psychologist participants revealed 63% of the sample were female. Thirteen percent fell within the age range 36-45 and 29% of the sample were trainee were (Appendix 5).

Table 3.1. Characteristics of Psychologist Participants

Component	Potential Response	Freq.	(%)
Age	<25	3	8
	26-35	7	18
	36-45	13	34
	46-55	10	26
	>55	5	13
Gender	Male	14	37
	Female	24	63
Ethnicity	White	30	79
	Asian	7	18
	Afro-Caribbean	1	3
Professsion	Clinical Psychologist	13	34
	Counselling Psychologist	19	50
	Chartered Psychologist	6	16
Student	Yes	11	29
	No	27	71
Work Place	Psychology Department	9	24
	Multi-disciplinary Team	3	8
	Health Centre	1	3
	In-patients Department	1	3

	Private	24	63
Years in Practice	<2 years	5	13
	2-5 years	7	18
	6-10 years	15	40
	11+ years	11	29
Approach	EMDR	10	26
	CBT	10	26
	Person Centred	8	21
	Intergrative	10	26

Female therapists accounted for 63% (n=24) of the sample and were predominantly White (79%). Thirty-four percent of the therapist sample were aged between 36-45 years old (n=13). Fifty percent of the sample were counselling psychologists (n=19), 34% were clinical psychologists (n=13) and 16% were chartered psychologists (n=6). Students accounted for 29% of the sample (n=11) and the majority of therapist had been practicing between 6-10 years (40%). Distribution of therapeutic approach was relatively similar with EMDR, CBT and integrative approaches all accounting for 26% (n=10) and person-centered explained 21% (n=8; See Table 3.1).

3.4.2. Inclusion/Exclusion Criteria for Psychologists

Psychologists must be working in private practice and have chartered status or training towards this.

3.4.3. Clients

Psychologist participants selected one of their clients attending their first therapy appointment. The sample contained 38 client participants, therefore, generating 38 therapist-client combinations. Sixteen percent of clients were attending therapy for depression, 26% for anxiety and 58% for both. Sixty percent of clients were female (Appendix 10). Eleven percent fell within the age range 26-35, and 63% of clients had received some form of counselling before.

Summaries of client characteristics are presented in Table 3.2. Most of the client participants were female (61%), White British (76%) with the most prevalent age range being 26-35 (29%). Fourty-seven percent of clients were married, and 58% had children (n=22). Clients were primarily attending therapy for both anxiety and depression combined (58%), and 63% of clients had previous experience of therapy (n=24).

Table 3.2. Characteristics of Client Participants

Component	Potential Response	Freq.	(%)
Age	<25	9	24
	26-35	11	29
	36-45	9	24

	46-55	6	16
	>55	3	8
Gender	Male	15	40
	Female	23	61
Ethnicity	White	29	76
	Asian	7	18
	Afro-Caribbean	1	3
	Other	1	3
Relationship Status	Married	18	47
	Single	10	26
	Divorced	5	13
	Widowed	1	3
	Cohabiting	4	11
Sexual Orientation	Heterosexual	33	87
	Gay	2	5
	Bisexual	1	3
	Prefer not to comment	2	5
Children	Yes	22	58
	No	16	42
Counselling Before	Yes	24	63
	No	14	37

Disorder	Anxiety	10	26
	Depression	6	16
	Both	22	58

3.4.4. Inclusion/Exclusion Criteria for Clients

The inclusion criteria were that; participants should be adults attending their first therapy session; aged 18-65 accessing adult mental health services with anxiety and/or depression (includes those experiencing anxiety, depression, or both, as a result of other mental health difficulties i.e. post-traumatic stress disorder; PTSD). The therapeutic intervention they are undertaking must take the form of CBT (Cognitive Behavioural Therapy), EMDR or person centred therapy and client participants must be literate in English. The exclusion criteria were being assessed by their psychologist to be in crisis or having symptoms of psychosis; bipolar; suicidal behaviour; illiterate in English and any condition requiring hospitalisation.

3.5. Materials

See appendices for participant invitation letter (Appendix 1; Appendix 7), information letter (Appendix 2; Appendix 8), consent form (Appendix 4; Appendix 9), demographic data (Appendix 5; Appendix 10) and debrief (Appendix 16). Four questionnaires were used to measure the key variables of interest in the study. These are described below:

3.5.1. Relationship Structures Questionnaire (ECR-RS)

The experience in close relationships – relationship structures questionnaire (ECR-RS; Fraley, Niedenthal, Marks, Brumbaugh & Vicary, 2006) is a self-report tool designed for researchers and

practitioners interested in evaluating patterns of attachment in a variety of close relationships. Both the therapist and the client completed the questionnaire at session one of therapy to identify their attachment style. The attachment relationships to four targets (i.e., mother, father, romantic partner, and best friend) are assessed using the same nine items. This is possible due to item wording, which allows them to assess multiple interpersonal targets (not just romantic relationships) for a range of age groups. For example 'I prefer not to show this person how I feel deep down'. Respondents are required to state how much they agree or disagree with a statement using a 7- point Likert scale, (with responses ranging from 1 = strongly disagree to 7 = strongly agree) for each interpersonal relationship. Fraley et al., (2011) reported a Cronbach's alpha of.90

The ECR-RS has two subscales, one for attachment-related anxiety and the other for attachment-related avoidance. Three items (7-9) measure the attachment-related anxiety dimension while six items (1-6) measure attachment-related avoidance. Scores are obtained by averaging the subscales for each target (i.e., mother, father, partner, friend). Scores for items 1-4 in the attachment-related avoidance dimension are reversed. To obtain a global score for attachment (as required in this study) scores need to be averaged across the domains. For example, the general attachment score for avoidance would be the average avoidance score with mother, father, partner, and friend. This would be the same for global attachment score for anxiety. The problems associated with this method are that it weights each domain as equal and dilutes the variance, which may not be advisable depending on what you are using the tool for. However, for the purpose of this study, this method was necessary and is recommended by Fraley et al. (2006). A table has been generated to display how scores characterise which general style of attachment participant's hold.

Table 3.3. Attachment Categories

Anxious subscale	Avoidant subscale	Attachment Style
≤ 3.5	≤ 3.5	Secure
≤ 3.5	≥ 3.5	Preoccupied
≥ 3.5	≤ 3.5	Dismissive
≥ 3.5	≥ 3.5	Fearful

*≥ = Greater than or equal to **≤ = Less than or equal to

The ECR-RS was chosen due to its properties of measuring current states of global attachment as opposed to romantic attachment. It allows contextual relationships to be measured such as parental, platonic friendships and romantic relationships. However, the tool is not restricted to these specific targets. It was designed to be flexible and used with any target that activates parts the attachment system (secure base). This may include, siblings (Tancredy & Fraley, 2006), relationships to teachers or counsellors (Meyer & Pilkonis, 2001), relationships to pets (Kurdek, 2009), relationships to God (Kirkpatrick, 1998). For the purpose of this research the domains suggested in Fraley's original design are used. It is theoretically aligned with the hypotheses and is able to derive dimensions of attachment and the four styles of attachment as established by Bartholomew and Horrowitz (1991). In addition, it is a valid and reliable measure of attachment (Fraley, Heffernan, Vicary, & Brumbaugh, 2011) (Appendix 6).

3.5.2. Patient Health Questionnaire (PHQ-9)

The PHQ-9 (Kroenke, Spitzer, & Williams, 2001) is a self-report tool that is frequently used in clinical settings. It comprises of 9 items that measure depressive symptoms based on the DSM-IV diagnostic criteria for depression (American Psychiatric Association, 1994). Respondents were required to state how often they have experienced certain difficulties in the last two weeks i.e. 'Feeling bad about yourself - or that you are a failure or have let yourself or your family down?' Participants respond on a 4-point Likert scale (ranging from 0 = not at all to 3 = nearly every day) and responses are combined to generate a possible Therefore of scores of 0-27. The cut-off point for mild depression is a score of 5; moderate depression has a cut-off point of 10; moderately severe depression has a cut-off score of 15, and severe depression is a cut-off score of 20. Internal consistency for the PHQ-9 is .88.

The PHQ-9 was completed at session one to establish a baseline and again at session six to identify any differences. The choice to use this instrument within this study falls largely around its brevity, criterion and construct validity, NICE guidelines recommendation, ability to screen, diagnose and assess severity and finally its widespread use in clinical settings, which allows practitioners to generalise findings to clinical populations. In the last decade, the PHQ-9 was studied for its ability to perform as an outcome measure. Löwe, Kroenke, Herzog and Gräfe (2004) found the PHQ-9 to be successful in detecting depression outcome and variations over time. More recently Kroenke, Spitzer, Williams and Löwe (2010) conducted a systemic review of the effectiveness of the PHQ-9's ability to detect and monitor depression. To which their research concluded it is a well-validated measure (Appendix 11).

3.5.3. Generalised Anxiety Disorder Questionnaire (GAD-7)

The GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006) is a brief self-report screening tool for anxiety that is frequently used in clinical settings. It comprises of 7 items related to anxiety symptomatology. Respondents are required to state how often they have experienced certain difficulties in the last two weeks (i.e.'Not being able to stop or control worrying'). Participants respond on a 4-point Likert scale (ranging from 0 = not at all to 3 = nearly every day) and responses are combined to generate a possible Standardised of scores of 0-27. Cut-off points for mild are a score of 5; moderate anxiety is a cut off score of 10 and 15 for severe anxiety. The GAD-7 has excellent Internal consistency (Cronbach's alpha of .89).

The GAD-7 was completed at session one to establish a baseline and again at session six to identify any change. Similar to the PHQ-9, the choice to use this instrument within this study falls largely around its brevity, criterion, construct, factorial and procedural validity (Spitzer et al 2006), NICE guidelines recommendation, ability to screen, diagnose and assess severity and finally its widespread use in clinical settings, allowing practitioners to generalise findings to clinical populations. The systemic review mentioned in section 3.5.2., by Kroenke et al., (2010) included the effectiveness of the GAD-7. Their finding illustrated that the GAD-7 is a well-validated measure for detection and monitoring of anxiety.

3.5.4. Revised Helping Alliance Questionnaire (HAq-II) -Therapist and Client Versions

The HAq-II (Luborsky et al., 1996) is a clinical tool designed to measure the construct of the therapeutic alliance between client and therapist using parallel forms. It is a self-report instrument, which requires respondents to rate their level of agreement for 19 statements on a 6-point Likert scale (1 = I strongly feel it is not true, 6 = I strongly feel it is true). For example, the

client version includes statements such as ‘I feel I can depend on the therapist’ whereas the therapist version includes the same statement that is tailored accordingly ‘the patient feels he/she can depend on me.' The internal consistency of this questionnaire has an average Cronbach’s alpha of .90 for both client and therapist versions (Luborsky et al., 1996).

The HAq-II was completed by the therapist and the client at session six to identify the strength of the therapeutic relationship. Session six was deemed appropriate for the second time point measurement due to time restraints and previous research has revealed that the alliance becomes established following session three of therapy (Ligiero & Gelso, 2002). Therefore this information combined with the need for outcome measures to be assessed at an appropriate second time point, session six was the most fitting for this research.

Adding positively worded items to reverse scored negatively worded items (4, 8, 11, 16, and 19) provides a total score for the Haq-II. Scores falling below 86 is considered to equate to a poor alliance, and above represents a good therapeutic alliance (Luborsky et al., 1996).
The HAQ-II is designed to measure how well the client and therapist work together (Johnson, 2010). Previous comparable research has implemented the WAI (Working Alliance Inventory; Horvath & Greenberg, 1989) and the CALPAS (The California Psychotherapy Alliance Scale; Gaston, 1991). The HAQ-II, CALPAS, and WAI are all commonly used, and not one can be recommended over the other (IsHak, Burt, & Sederer, 2002). However, the decision to implement the HAQ-II was due to the HAQ-II score relating to a client’s satisfaction of therapy rather than symptomatic improvement, which was measured using the PHQ-9 and GAD-7 as detailed above. The HAQ-II was conducted at session six of therapy as research suggests that the critical foundations of the therapeutic relationship are established within the first five sessions of

therapy (e.g., Horvath, 1981; Horvath & Luborsky, 1993; Saltzman, Luctgert, Roth, Creaser, & Howard, 1976; Appendix 14; Appendix 15) therefore, this was the basis for procedure design.

3.6. Data Analysis

From previous research we can hypothesise that:

- Securely attached therapists will have a stronger therapeutic alliance with clients.
- Securely attached therapists will provide the greatest change in symptom severity.

However, for the purpose of this new research the following hypotheses will be tested:

1. The interaction between therapist attachment and client attachment will have a statistically significant affect on symptom severity in clients

2. The interaction between therapist attachment and client attachment will be a statistically significant predictor of the therapeutic alliance

In addition to the main hypothesis, this research will attempt to answer the following questions:

1. Which attachment style combinations provide better therapeutic relationships?

2. Which attachment style combinations provide better therapeutic outcomes?

To test the hypothesis and answer the research questions, the approach of the study consisted of measuring therapist' attachment style and client attachment style at session one of therapy. The compatibility between attachment styles (independent variable) was determined by changes in psychometric outcome measures (dependent variable), which was collected at session one of

therapy and again at session six. In addition, client and therapist completed a measure for the therapeutic alliance (dependent variable) at session six of therapy enabling the researcher to determine any correlations between attachment style and therapeutic alliance.

3.7. Procedure

Any psychologist listed in the online directory on the BPS or EMDR website to be working in private practice was invited (Appendix 1) via email to take part in the study. Those who agreed to take part were posted a research portfolio containing four packs (two for the psychologist and two for the client). Pack one for the psychologist included a detailed information sheet (Appendix 2), consent form (Appendix 4), research protocol (Appendix 3), demographic questionnaire (Appendix 5) and the ECR-RS (Appendix 6). Pack one for the client contained an Invitation letter (Appendix 7), a detailed information sheet (Appendix 8), consent form (Appendix 9), demographic questionnaire (Appendix 10), the ECR-RS (Appendix 13), PHQ-9 (Appendix 11) and the GAD-7 (Appendix 12). Pack two for the therapist included the HAq-II (Appendix 14) and a debrief sheet (Appendix 16). Pack two for the client contained HAq-II (Appendix 15), the PHQ-9 (Appendix 11), the GAD-7 (Appendix 12) and a debrief sheet (Appendix 16). Additionally, the portfolio contained a GP letter should the therapist choose to inform the client's GP of their participation in the study and a stamped addressed envelope in order to return questionnaires once completed at the end of session six of therapy.

3.7.1. Psychologist participants

Following their consent to take part, therapists were asked to recruit a client attending their first session of therapy that qualified for the recruitment criteria (Adult 18-65, receiving CBT, EMDR or person centred therapy for anxiety or depression which could be a part of a comorbid diagnosis). They asked a client if they would be happy to take part in a study exploring the interaction between attachment styles and the therapeutic relationship. Therapists provided their client with an information leaflet that explained the study in more detail, including what was expected of them, elements of risk and how the information would be used. If the client agreed, they completed the consent form, followed by the contents of pack one and returned it to their therapist to retain. Therapists were asked to complete their pack one at session one of therapy and retain both the client's completed documents and their own until the completion of session six.

At session six the therapist was asked to complete the contents of their pack two and ask their client to complete pack two. The therapist then returned the completed questionnaires from pack one and two for both the client and themselves in the stamped addressed envelope.

3.7.2. Client Participants

Therapists asked clients attending their first session of therapy that met the inclusion criteria (Adult 18-65, receiving CBT, EMDR or person centred therapy for anxiety or depression which could be a part of a comorbid diagnosis) if they would be happy to take part in a study exploring the interaction between attachment styles and the therapeutic relationship. Therapists provided their client with an information leaflet that explained the study in more detail, including what was expected of them, elements of risk and how the information would be used (see Appendix 7

and Appendix 8). If the client agreed, they completed the consent form, followed by the contents of pack one and returned it to their therapist to retain. At session six of therapy, clients completed the contents of pack two and returned them to their therapist.

3.8. Ethical considerations

3.8.1. Respect for the autonomy and dignity of persons

Throughout the research process, the dignity of all participants was respected with particular value being placed on participant's rights of privacy and self-determination' (Code of Ethics and Conduct, 2009, p.10)

3.8.2. Scientific value

The research was designed and conducted in such a way that ensured quality and input to the development of knowledge and understanding.

3.8.3. Maximising benefit and minimising harm

As per the Ethics Principle 3: Responsibility of the Code of Ethics and Conduct, research was considered from the participants perspective with the aim of avoiding prospective risks to their psychological well-being, personal values, mental health or dignity. See below for these considerations.

3.8.4. Risk

The risks of this research were carefully considered throughout the research process and were kept to a minimum. Apparent risks are as follows; Psychologist participants may have found it a burden on their time to hand out the questionnaires. However, existing practice often requires clients to complete psychometric tests that clients were asked to complete. The responsibilities of the therapist and the time they would need to spend on this. Therefore in the therapist information sheet. Client participants may have found elements of the outcome measures and attachment questionnaire distressing. However, the GAD-7 and PHQ-9 are often part of routine protocol. Therefore the risks were considered to be no greater than usual treatment. The additional questionnaires for attachment and the therapeutic relationship are the least distressing among measure. Clients were advised to discuss any discomfort with their psychologist as part of normal practice.

3.8.5. Valid Consent

Inline with the Code of Ethics and Conduct, participants freely consented to participation in the study. They were advised of their right to withdraw from the study at any point (see Appendix 4 and Appendix 9 for consent form). It is always possible that coercion could occur and in this study client's may have been put in a position of relative powerlessness and feeling beholden to accepting and that their therapy may be impacted should they decline. However, each therapist participant was a member of a professional body and subscribed to the BPS ethical principles. It was expected that this would have been minimised due to their level of ability and expertise. In addition, the client information form stated that they were under no obligation to take part.

3.8.6. Confidentiality

Inline with the requirements of the Data Protection Act and legislation, participant data remained completely confidential and unidentifiable with the use of coding that was implemented by the researcher. Due to clients handing their response sheets back to their therapist in an unsealed envelope, therapists were able to see their client's answers to the questionnaires for session one. However, without the scoring information they would be unable to identify the meaning behind them. If for some reason they did obtain the scoring information they would only be aware of a clients attachment style and their severity of symptoms for anxiety and depression. Given the nature of a therapists profession, it is more than likely that a therapist would have an understanding of this information about the client by the end of session one anyway. For the answers provided to session six questionnaires by a client, these are sealed in the envelope with session one answers and returned to the researcher.

3.8.7. Giving Advice

No advice was provided during this study

3.8.8. Deception

Participants were not deceived during this study

3.8.9. Debriefing

In line with the Code of Ethics and Conduct, participants were debriefed following the study. This included the aims of the study and how the data collected would be used.

Chapter 4 – RESULTS

4.1. Description of sample

The sample consists of 38 psychologists, 38 client participants and therefore, 38 therapist-client dyads. This met the criteria as defined by Cohen (1992) that more than 30 subjects were sufficient to achieve a decent level of statistical significance for multiple regression models.

60.5% of therapists were securely attached, 18.4% were preoccupied, 7.9% dismissive and 13.2% were fearful (see Table 4.1). 50% of clients were securely attached, 5.3% were preoccupied and dismissive, and 39.5% were fearful.

Table 4.1. Attachment Orientation For Client and Therapist

Attachment Orientation	Client Freq.	Client %	Therapist Freq.	Therapist %
Secure	19	50	27	60.5
Preoccupied	2	5.3	7	18.4
Dismissive	2	5.3	3	7.9
Fearful	15	39.5	5	13.2

53% of the client-participants had a moderately severe to severe level of depression before the therapy session, but at post-therapy, 14% of the participants reported a level of depression that was considered moderately severe and severe according to scores on the patient health questionnaire (Table 4.2). Client anxiety levels also reduced after therapy sessions with only 3% (n = 1) of the participants having a severe; the of anxiety post-therapy compared to 47% (n = 17)

of the participants that had moderately severe and severe level of anxiety before therapy (see Table 4.2).

Table 4.2. Frequency of Client-Participants classified at each level of severity for Anxiety And Depression

	Depression Score Pre Therapy		Depression Score Post Therapy		Anxiety Score Pre Therapy		Anxiety Score Post Therapy	
Outcome	Freq.	(%)	Freq.	(%)	Freq.	(%)	Freq.	(%)
Minimal	2	(5.3)	7	(18.4)	3	(7.9)	10	(26.3)
Mild	4	(10.5)	15	(39.5)	4	(10.5)	21	(55.3)
Moderate	8	(21.1)	11	(28.9)	14	(36.8)	6	(15.8)
Mod-Severe	11	(28.9)	4	(10.5)	10	(26.3)	1	(2.6)
Severe	13	(34.2)	1	(2.6)	7	(18.4)	0	(0)

4.2. Preliminary Analysis of Data

Data were pooled and entered into SPSS for analysis. For the purpose of addressing the research question to identify the attachment style combination that will provide better outcomes (reduction in depression and/or anxiety) in therapy, it was necessary to determine 16 categories, which described the pairing of therapists and clients with respect to their attachment style. As such, descriptive statistics were carried out in SPSS to establish whether the cell sizes represented by these sixteen combinations were sufficient for parametric analyses, or if

categorising participants as secure or insecure would result in more suitable cell sizes (Table 4.3). Using cell sizes allowed for the directionality of the correlation, and the dependence between the variables to be interpreted with greater ease by looking at the differences between observed and expected counts and percentages. This was necessary to facilitate in answering the research questions. Table 4.3 presents the observed values. It can be inferred from Table 4.3 that a secure client and therapist combination provided the greatest change in symptoms and perceived the therapeutic relationship to be good. However, the cell sizes were deemed too small for further parametric analyses, where this more detailed breakdown of insecure attachment was used (e.g. preoccupied, dismissive and fearful) (Table 4.3). Therefore to work with the data, an alternative method was used which may be considered reductionist but was necessary for this instance. This is discussed in section 4.6 below.

Table 4.3. Mean And Standard Deviations For Changes In Outcome Measures And Perceived Alliance Of Client And Therapist Based On Attachment Combinations.

Comb	N	Depression Change Mean (SD)	Anxiety Change Mean (SD)	Therapist Alliance Raw Mean (SD)	Client Alliance Raw Mean (SD)
CSecure_ TSecure	9	9.1 (6.1)	11.2 (5.4)	105.6 (5.0)	102.6 (13.2)
CSecure_ TPreoccupied	5	4 (3.7)	3.4 (3.7)	94.0 (11.1)	96.4 (13.0)

CSecure_TDismissive	1	4.0	3.0	114.0	109.0
CSecure_TFearful	4	4.3 (2.8)	4 (2.5)	80.25 (8.6)	76.00 (12.7)
CPreoccupied_TSecure	1	9.0	10.0	100.0	114.0
CPreoccupied_TPreoccupied	1	10.0	15.0	85.0	92.0
CDismissive_TSecure	2	8.5 (0.7)	4.5 (0.7)	95 (26.9)	98.0 (22.6)
CFearful_TSecure	11	7.8 (3.7)	5.6 (3.2)	104.2 (11.4)	101.7 (13.6)
CFearful_TPreoccupied	1	14.0	10.0	74.0	88.0
CFearful_TDismissive	2	5.5 (6.4)	5.5 (6.4)	81.0 (1.4)	83.5 (10.6)
CFearful_TFearful	1	10.0	11.0	81.0	89.0
Total	38	86.2	83.2	1014.05	1050.2

Following this, the reliability and validity of variables were assessed. Cronbach's alpha demonstrated strong internal consistency on the following scales: pre-study PHQ Questionnaire (r = .885), post-study PHQ Questionnaire (r = .869), pre-study GAD-7 (r = .905), post-study

GAD-7 (r = .893), therapist helping alliance questionnaire (THA) (r = .94), client helping alliance questionnaire (CHA) = .921, therapist attachment questionnaire (r = .916), and the client attachment questionnaire (r = .957). Factor validity was used to assess the measures mentioned above to know the validity amongst the variables. Measures were found to perform satisfactorily and the analyses can be found in Appendix 18. It may be argued that factor validity is unnecessary given the small cell sizes. However, multiple researchers have argued that if the ratio of subject to variables is above five, the analysis is acceptable (Arrindell & Van der Ende, 1985; Bryant and Yarnold, 1995; Gorsuch, 1990; MacCallum, Widaman, Zhang, & Hong, 1999).

4.3. Research Question 1: Which attachment style combinations provide better therapeutic relationships?

In order to test the hypothesis that there will be a statistically significant negative relationship between global anxiety and avoidance and therapist and client alliance, Pearson correlations were examined. The relationship between anxiety and depression was also examined with the same test. Therapist alliance and client alliance both have a statistically significant moderate negative centred with Therapist global Anxiety (r = -.666, r = -.520) and Avoidance (r = -.455, -.506), showing that lower scores on therapist Anxiety and Avoidance tends to lead to better alliances. That is, a more securely attached therapist (See Table 4.4) is associated with a more positive alliance. This result supports the hypothesis that there will be a statistically significant negative relationship between global anxiety and avoidance and therapist and client alliance.

4.4. Research Question 2: Which attachment style combinations provide better therapeutic outcomes?

To examine the hypothesis that attachment would be associated with psychological outcomes, correlations were firstly examined. There was a statistically significant negative relationship between depression change (the difference between pre-depression and post-depression scores) and therapist global anxiety (r = -.396), and therapist global avoidance (r = -.405), which means there is an improvement in depressive symptoms with a more securely attached therapist (Table 4.4). This result supports the hypothesis that securely attached therapist will lead to a greater reduction in therapeutic outcomes.

Table 4.4. Correlations between alliance, attachment and relevant outcome variables.

Correlations	1	2	3	4	5	6	7
1. Client Global Anxiety							
2. Client Global Avoid	.819**						
3. Therapist Global Anxiety	-0.082	-0.181					
4. Therapist Global Avoid	-0.116	0.019	.420**				
5. Depression Change	0.121	0.07	-.396*	-.405*			
6. Anxiety Change	-0.111	-0.192	-0.282	-.321*	.662**		

7. Therapist Alliance Mean	-0.126	-0.016	-.666**	-.455**	0.2	0.104	
8. Client Alliance Mean	0.022	0.104	-.520**	-.506**	.372*	0.313	.757**

Key: *= p < .05, ** = p < .01, n = 38

4.5. Hypothesis 1: The interaction between therapist attachment and client attachment will have a statistically significant affect on symptom severity in clients

To test the hypothesis that the combination of therapist and client attachment styles would explain more variance in psychological outcomes (depression and anxiety) than therapeutic alliance, regression analyses were conducted.

To represent the combined attachment of therapist and client within the analyses for the present study, firstly a single indicator of attachment was created for each participant. This was achieved by multiplying attachment anxiety by attachment avoidance. It is indicated that anxiety and avoidance scores can be combined if there is a need to get one global style of attachment (Fraley, Niedenthal, Marks, Brumbaugh & Vicary, 2006). This score was then centered (subtracting the mean from the participant's score) to standardise the scores (Miles & Shevlin, 2001). Finally, the therapist attachment score was multiplied by the client attachment score. The need for scores to be combined was to test whether particular combinations will be more favourable than another. Showing that lower scores on Anxiety and Avoidance tends to lead to better alliances supporting the hypothesis that there will be a statistically significant negative relationship between global anxiety and avoidance with the therapeutic alliance, and changes in

symptom severity (outcomes). Data were managed using syntax, and this file can be found in Appendix 21.

Separate analyses were conducted for outcomes in depression and outcomes for anxiety. The alpha level was partitioned accordingly; consequently, a probability value of $p < .025$ (.05 / 2) was the criterion for statistical significance in the main analyses. This was necessary as it allows for the relationship to be tested in both directions. For example the score for depression following therapy sessions may have increased or decreased and this is important for testing the hypothesis. Due to the nature of the data being dyadic, each dyad is treated as a participant for the purpose of the regression analysis. For the interaction analyses, the outcome of the analysis was defined as the r2 change and the significance of the change between the model without the interactions, and the model including the interactions, rather than the significance of individual regression lines.

A preliminary multiple regression was performed (n=38). Predictor variables were entered in three blocks, the change in depression scores from pre to post-test served as the outcome variable. In the first block, the predictor variables were the clients' alliance raw scores and the therapists' alliance raw scores. Block two contained single indicators for client attachment (c_att) and therapist attachment (t_att). In the third block, the interaction term was added, which was CxT (the interaction between client and therapist attachment). It can be argued that the small sample size alongside several predictor variables produces a weaker result. However several researchers advocate the rule of thumb that for every variable there should be ten participants, which is true of this study (Knofczynski & Mundfrom, 2008).

Multicollinearity for the first regression block was assessed by the Variance inflation factor (VIF) values. Myers (1990) and Bowerman and O'Connell (1990) as cited by Field

(2005) indicated that multicollinearity was only cause for concern if the largest VIF is greater than 10, or if the average VIF is greater than 1. VIF values are well below 10, and tolerance levels above .2, and thus, multicollinearity is not assumed to be an issue with the regression models under investigation. As the same predictors are used for both analyses, this did not need to be repeated with anxiety as an outcome variable. Standardized residual plots were examined and the regression assumptions of homogeneity, linearity and normality were not violated. The Durbin-Watson statistics for auto-correlation was 2.09, indicating independence of the residuals. No multivariate outliers were detected using Mahalanobis distance (Mahalanobi, 1936).

For the main analysis regression analysis was applied with 38 therapist-client dyads. The predictors were entered in blocks as for the preliminary analyses described above.

4.5.1 Depression

The first regression block accounted for 15.3% of the variance in the prediction of depression; the multiple correlation coefficient was .37 ($F = [2, 35]$ 3.173; $p = .054$. The second regression block with client and therapist attachment accounted for 30.7% of the variance, the multiple correlation coefficient was .55 ($F = [4, 33]$ 3.656; $p < .05$). The r2 change between the two models was .154 (F change = [2, 33] 3.656; $p < .05$; Table 4.5).

The third regression block, including the interactions, accounted for 31.2% of the variance, the multiple correlation coefficient was .56 ($F = [5,32]$ 2.90; $p<.05$). The r2 change between the second and third regression model was .005 (F change = [1, 32] 8.09; $p = .641$)(table 5). These findings did not support the proposed hypothesis that the interaction between therapist attachment and client attachment will have a statistically significant effect on depression in clients (Table 4.5).

An examination of the beta weights, the zero order, and the semi-partial correlations from the final step (Table 4.6), demonstrated that only client alliance made significant unique contributions to the reduction of scores for depression in clients.

Table 4.5. Model Summary For Depression

			Change Statistics				
			R Square				
Model	R	R Square	Change	F Change	df1	df2	Sig. F Change
1	.392[a]	.153	.153	3.173	2	35	.054
2	.554[b]	.307	.154	3.656	2	33	.037
3	.558[c]	.312	.005	.222	1	32	.641

Table 4.6. The Effect of Client attachment, therapist attachment. Client alliance, therapist alliance and the interaction between C and T on Depression Beta Weights, Zero Order and Semi-Partial Correlations at the Final Step

Predictors	Standardized Beta	t	α	Zero Order	Partial
Client Alliance	.516	2.167	.037	.372	.344
Therapist Alliance	-.190	-.800	.429	.200	.134
Therapist Alliance	-.235	-1.058	.298	.200	-.181
Client Alliance	.554	2.427	.021	.372	.389

C_Attachment	.307	2.030	.051	.393	.333
T_Attachment	.202	1.302	.202	.136	.221
Therapist Alliance	-.243	-1.077	.289	.200	-.187
Client Alliance	.538	2.310	.027	.372	.378
C_Attachment	.266	1.507	.142	.393	.257
T_Attachment	.138	.664	.511	.136	.117
CxT	.107	.471	.641	.345	.083

Key: C = Client Attachment, T = Therapist Attachment

Overall, it appears that the addition of continuous scores for client attachment slightly enhance the predictability of clients' alliance raw scores, and help explain some of the variation in the changes in depression scores generally for regression block two. The regression block two explains the most variation in the outcome variable. However, the addition of interaction scores between therapist and client in model three weaken the model and lessen the impact of clients' alliance raw scores in model three.

4.5.2. Anxiety

The analysis was repeated, substituting change in depression for anxiety as the outcome variable.

As Table 4.7 shows, the predictor variables in all three models do not share a significant relationship with changes in anxiety as a response variable ($p > .05$).

Table 4.7. ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	119.831	2	59.915	2.834	.072b
	Residual	740.064	35	21.145		
	Total	859.895	37			
2	Regression	157.353	4	39.338	1.848	.143c
	Residual	702.542	33	21.289		
	Total	859.895	37			
3	Regression	184.088	5	36.818	1.743	.153d
	Residual	675.807	32	21.119		
	Total	859.895	37			

Table 4.8 indicates that clients' alliance raw scores have a significant relationship with changes in anxiety scores, but that the addition of the other variables in each model rendered the association between the response and predictor variables non-significant overall.

Table 4.8. Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.366	5.529		.066	.948
	TherapistAlliance Raw	-.108	.084	-.311	-1.295	.204
	ClientAlliance Raw	.177	.077	.548	2.286	.028
2	(Constant)	-1.174	5.859		-.2	.842
	TherapistAlliance Raw	-.115	.084	-.329	-1.362	.182
	ClientAlliance Raw	.191	.08	.594	2.398	.022
	c_att	.249	.402	.102	.621	.539
	t_att	.514	.509	.17	1.01	.32
3	(Constant)	.949	6.134		.155	.878
	TherapistAlliance Raw	-.122	.084	-.349	-1.445	.158
	ClientAlliance Raw	.179	.08	.555	2.228	.033
	c_att	-.008	.461	-.003	-.018	.986

t_att	.02	.67	.007	.031	.976
CxT	.34	.302	.273	1.125	.269

4.6. Hypothesis 2: The interaction between therapist attachment and client attachment will be a statistically significant predictor of the therapeutic alliance

4.6.1. Therapist Alliance

Multiple regression analysis was carried out to examine whether client attachment, therapist attachment and the interaction between client and therapist attachment will be a statistically significant predictor of therapist alliance.

The result of the analysis did not reach statistical significance and this shows that the regression model is not a statistically significant predictor of therapist alliance ($F(3,34) = 1.969$, $p > .05$)(See Table 4.9).

Table 4.9 Regression Model Predicting Therapist Alliance

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2.900	3	.967	1.969	.137
	Residual	16.689	34	.491		
	Total	19.589	37			

4.6.2. Client Alliance

Multiple regression analysis was also carried out to examine whether client attachment, therapist attachment and the interaction between client and therapist attachment will be a statistically significant predictor of client alliance.

As Table 4.10 shows, the regression model is not a statistically significant predictor of client alliance ($F(3,34) = 1.538$, $p > .05$)(See Table 4.11).

Table 4.10. Regression Model Predicting Client Alliance

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4.615	3	1.538	2.847	.052
	Residual	18.373	34	.540		
	Total	22.988	37			

Chapter 5 – DISCUSSION

The aim of this study was to examine the interaction between therapist attachment styles and client attachment styles. Importance was placed on the impact of this interaction on the therapeutic relationship and the outcome of therapy, which was determined by a change in depression and anxiety scores.

This study has generated some important findings highlighted below:

- Clients' perceived alliance is the significant contributing factor to change in depression and anxiety
- Securely attached therapists provide stronger therapeutic relationships
- Securely attached therapists lead to a greater reduction in depression severity
- Reduction in the severity of depression and anxiety overall

The hypotheses that interactions between client-therapist attachment dyads would impact the therapeutic alliance and client symptom severity were not supported. Therefore the strength of the therapeutic alliance and the reduction of symptom severity are not predicted by the interaction between therapist and client attachment. Overall only 31.2% of the variance could be explained by the regression analysis therefore 68.8% is the result of something not accounted for within the analysis. It could be argued that any variance accounted for by the predictor variables was so small as a result of sample size that it failed to be revealed. The study did, however, find a significant correlation between securely attached therapists and the reduction of depression severity. Thus supporting previous research that securely attached therapists will provide the

greatest change in symptom severity. The correlational analysis found therapists' with a secure attachment style showing a stronger therapeutic relationship as perceived by the client and the therapist. This is in agreement with previous research that securely attached therapists will have a stronger therapeutic alliance with clients. In addition to supporting previous research discussed in chapter two which advocates that securely attached therapists have an increased advantage when working with multifaceted client difficulties (Dozier & Tyrrell, 1998; Dozier, Cue & Barnett, 1994; Mallinckrodt & Jeong, 2015; Mallinckrodt, Porter & Kivlighan, 2005). Attachment representations of 31 therapists were measured using the Adult Attachment Interview (AAI) and correlated with 1,381 client responses on the strength of the therapeutic alliance using the Helping Alliance Questionnaire (HAQ) (Schauenburg et al., 2010). Their results concluded an interaction between therapist attachment and client symptoms that therefore impacted the therapeutic relationship. Increased attachment security in therapists was related to a better therapeutic relationship as perceived by the client. However, this association was limited to clients that depicted increased interpersonal difficulties and with clients displaying elevated distress levels before therapy (Schauenburg et al., 2010).

5.1. Research Question 1: Which Attachment Style Combinations Provide Better Therapeutic Relationship?

From the descriptive statistics (Table 3) it is observed that clients' with a preoccupied attachment classification and therapists with a secure attachment classification had the strongest client rated alliance score. This contradicts findings by Bucci, Seymour- Hyde, Harris and Berry (2015) who found no correlation in their study as they measured the relationship between client and therapist self-reported attachment styles, the therapeutic relationship and psychological mindedness. They

argued that their small sample size might have impacted their findings. Descriptive statistics (Table 3) of the current research also exhibited clients that had an insecure attachment style regarded the therapeutic relationship as poor. This is in line with the findings of Bucci et al. (2015), and the meta-analysis conducted by Mallinckrodt and Jeong (2015) who reviewed research from 1995 – 2013 that correlated results from the Client Attachment To Therapist Scale (CATS) with global client attachment, client-rated alliance, or both. In light of this, it is worth considering the accuracy of the findings from this study, as similar to Bucci et al., (2015) sample size was not evenly distributed across attachment dyads.

5.2. Research Question 2: Which Attachment Style Combinations Provide Better Therapeutic Outcomes?

We can speculate from the results that a secure client-therapist dyad provided the greatest change in symptom severity for both anxiety and depression, in addition to having the strongest therapeutic alliance. Therefore, this would provide support to existing research that a stronger alliance contributes to a change in symptom severity, which is line with what this study intended to achieve.

5.3. Other Related Findings

A significant finding from the present study was the reduction of depression and anxiety scores as a result of the therapeutic relationship from the clients' perspective. Previous research has explored the similarities and differences of client and therapist opinions of the therapeutic alliance that can provide support for the findings of the current study. Bachelor (2013) examined elements that were pertinent to therapy participants, their relationship to post-therapy outcome

and the relationship between the alliance constructs of participants. The ratings of three therapeutic alliance measures for 176 clients and 133 therapists were assessed. Results indicated that the clients' view of the alliance contained six components comprising of a collaborative working relationship, commitment, agreement on goals/tasks, productive work, bond and confident progress. Five of these predicted post-therapy outcome of clients and/or therapists. The results for therapists proposed four elements comprising of a collaborative working relationship, the dedication and confidence of the therapist, the dedication and confidence of the client and the working ability of the client. Three of these components predicted the post-therapy outcome. Correlations amongst several joint client and therapist factors suggest that despite some parallels, clients' opinions of the relationship differ in significant ways. Clients appear to place greater emphasis on working collaboratively in therapy, helpfulness and signs of negativity within the alliance.

Similarly, as discussed in chapter two and in reference to the 68.8% variance not accounted for in this research, previous research indicates a significant correlation between the therapeutic relationship and client variables other than attachment, stating that the client's capacity to form a positive relationship underpinned the alliance (Black, Hardy, Turpin & Parry, 2005). This correlation by some researchers refers specifically to empathy as perceived by the client at the beginning of therapy (Horvath, 1981; Greenberg & Adler, 1989; Jones, 1988; Moseley, 1983) In addition, multiple researchers (Barrett-Lennard, 1986; Rogers, Gendlin, Kiesler, & Truax, 1967) have found therapists to have better outcomes with clients when elevated levels of empathy were offered. Horvath and Luborsky (1993) believed that client behaviour in sessions would mirror that of their therapist with the provision that the therapist possesses the appropriate attitude (Horvath & Luborsky, 1993). As stated in chapter two, it

could be inferred from findings of this study and previous studies that securely attached therapists offer more empathy. Research on the development of empathy describes a link between securely attached infants and the level of empathy displayed. Kestenbaum, Farber and Sroufe (1989) cited in McDonald and Messinger (2011) found that secure infants responded empathically on a more frequent basis than insecure infants and Kochanska, Forman, Aksan, and Dunbar (2005) found that infants whose parents were more responsive to their needs were more likely to behave empathically to distressed individuals. In addition, this would correspond with research also described in chapter two and findings from this study regarding the susceptibility of psychopathology in insecurely attached individuals. Therefore, therapists with an insecure attachment classification (avoidant or anxious) are likely to offer less empathy leading to poorer therapeutic relationships and reduced success with clients. Furthermore, with consideration to mirroring the therapists behaviour (Horvath & Luborsky, 1993) it could be argued that insecurely attached therapists are not providing the appropriate attitude. Therefore clients do not reflect the behaviour which then leads to poor outcomes overall.

If we refer to the therapeutic relationship through a psychoanalytical lens, therapists' are encouraged to provide an environment to the client that is safe and secure, affording them the opportunity to re-experience and process their feelings around distressing incidents. If a client perceives their therapist to be responsive to their needs within this environment, it can promote a stronger sense of self. This secure environment can also facilitate transference (see chapter two). Client projections (part of transference) have a greater chance of being recognised by the therapist if therapists present themselves as a 'blank slate' (Jacobs, 2005). This is achieved by abstaining from any self-disclosure, which in part prevents the client from becoming distracted (Jacobs, 2005). Within this therapeutic model, it could be argued that the therapists style of

attachment would not be brought into the therapeutic environment. In contrast, other models of psychology (e.g. cognitive behavioural therapy and person-centered) advocate the use of self-disclosure (Farber, 2003; Kirschenbaum & Jourdan, 2005) to enhance the relationship, as the client observes the therapist to be a real person. Consequently, amid these modalities, a sense of the therapist and their attachment style will be exposed within the therapeutic environment. A vast amount of research argues that it is the therapeutic relationship that is significant in promoting change independent of the model used (Ackerman & Hilsenroth, 2003; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). Therapist representation clearly differs in these models and from previous research we can infer that a client's view of these representations will also be different (Lorr, 1965; Thompson & Hill, 1993). In turn, this would have an overall impact on the clients' view of the therapeutic process and therefore the relationship. Every client will have a different opinion; however there may be some correlation between client opinions on the therapeutic relationship with therapists who self-disclose compared with those who present as a blank slate and attachment orientation.

An important finding worth stating overall is the reduction in depression and anxiety severity as a result of therapy. This is again in agreement with existing research advocating the effectiveness of therapy (Roth & Fonagy, 2013). By placing emphasis on this study's methodical considerations of collecting outcome measures at session six of therapy, together with descriptive statistics from this study that seven of the eleven available dyads within the study considered the relationship to be good also provides evidence to support previous research which asserts that the therapeutic relationship is established by session three of therapy (Ligiero & Gelso, 2002). While it is necessary to investigate the intricacies of the therapeutic environment,

recognition of its overall effectiveness in facilitating client change is worth acknowledgement to reconfirm the efficacy of therapy and provide support to the field of counselling psychology.

5.4. Limitations

The main limitation of this research was the sample size. The intention was to obtain an equal number of dyads in each of the 16 possible attachment combinations. As this was not achieved, a true reflection was not provided. Therefore, as a result of the participant sample being inadequate, it limited the possibility of statistical significance across findings.

More so, several researchers have found that the therapeutic alliance is established by session six of therapy. However, different results may have been found in this study if the Helping Alliance Questionnaire (HAQ-II) was administered at the end of therapy. Participants' holding a preoccupied style of attachment may have needed more time to trust and become comfortable in the environment. Some research has suggested that the relationship is at its strongest in the early stages of therapy (Sauer, Lopez, & Gormley, 2003).

If this is the case, then collecting the Helping Alliance Questionnaire (HAQ-II) at the end of therapy may also impact how a securely attached participant might respond. Other research argues that the relationship fluctuates (Kanninen, Salo, & Punamaki, 2000) as a result of the therapeutic process. This too would affect responses to the questionnaire depending on the time of administration. Therefore it would be necessary for any future research to consider these factors before deciding the time point for the collection of data.

The categories of attachment used in this study are considered by some to be less accurate than when using a continuous scale of attachment (anxious or avoidant) Fraley and Waller (1998) found that the styles of attachment are areas amongst a two-dimensional space and

that precision is lost whenever a typological measure is used in place of the continuous scales. Therefore, using this continuous scale may have generated a different outcome.

Finally, LaPiere (1934) indicated that attitudes on a questionnaire do not always reflect actual behaviour. Therefore, a qualitative approach or element within the study may also have reflected alternative findings.

5.5. Future Research

Conducting research provides a platform for the growth of new research areas and the correction of errors. With this in mind, this research has revealed several limitations (detailed within the limitations section) that may provide different outcomes if repeated. Also, new areas for prospective research within the field of attachment and the therapeutic relationship have been exposed.

A basic area for future research would be to replicate this study over a longer period of time and measure alliance at the end of therapy rather than at session six. This will enable a true representation of whether attachment interaction between client and therapist is predictive of the reduction in symptom severity and therapeutic alliance. Furthermore, it will enable the research that has found that the therapeutic relationship changes between sessions three, six and nine to be challenged (Ligiero & Gelso, 2002).

Dependent on the mode of therapy being offered it might be useful to measure whether therapists' provide the same environment (i.e. are they a blank slate or using self-disclosure) for all clients. Black, Hardy, Turpin and Parry (2005) explored the relationship amid therapists' self-reported attachment style and the therapeutic approach with a self-reported therapeutic alliance and therapist-reported difficulties in therapy. They found that the therapeutic approach used

predicted a small yet significant amount of the variance in the quality of global alliance above and beyond what was explained by attachment behaviours. From this, we can infer that the approach offered affects the therapeutic relationship thus providing a starting point for future research to expand research to identify whether those stating they do not use self-disclosure are in fact not. Is it at all possible for a therapist to inhibit any or all information that may reveal who they are? Secondly, to measure client opinions on the therapeutic relationship for therapists who self-disclose compared with therapists who present as a blank slate. With the aim to further correlate this with attachment orientation. Knowledge from this research would inform therapists of the approach preferred by a client depending on their attachment classification. For example, an anxiously attached client may prefer self-disclosure from a therapist, which would lead to a stronger therapeutic relationship and therefore therapeutic outcomes.

It could be argued that there were no significant findings for this research due to attachment orientation being unstable. How can there be an interaction between two components if one component changes? Research surrounding attachment stability is inconsistent. Some argue that it is stable, others argue that it can change or that there can be temporary variations (Fraley, Vicary, Brumbaugh, & Roisman, 2011) as a result of a significant life event but will then return to what it was previously. Future research similar to this study may want to include a measure of whether their attendance to therapy is the result of one life event or multiple life events. This would provide support toward existing research of whether attachment styles are stable over time and significant life events disrupt its stability before it then returns to how it was before therapy. However, another area to consider as a result of this might be the impact of this upon the therapeutic relationship. Moving from a place of crisis to a place of stability may see the client behave differently toward the therapist.

There is an alternative argument to be considered for the findings of this study that relate to clients with an insecure attachment classification having poor outcomes. This argument refers to the concept that a client's attachment insecurity pre-therapy restricts a productive working alliance (Bernecker, Levy, & Ellison, 2014; Deiner & Monroe, 2011; Mallinckrodt & Jeong, 2015; Mallinckrodt, Porter & Kivlighan, 2005; Schauenburg et al., 2010), a secure attachment to the therapist (Mallinckrodt & Jeong, 2015) and reduces positive therapy outcomes (Levy, Ellison, Scott, & Bernecker, 2011). Both Romano, Fitzpatrick and Janzen, (2008) and Mallinckrodt, Porter, and Kivlighan, (2005) suggested that a secure attachment to one's therapist provides a "secure base" (Bowlby, 1988) allowing clients to explore on a deeper level midway through the therapy process (Mallinckrodt et al., 2005; Romano et al., 2008). The question worth consideration subsequently is how are therapists likely to surmount these challenges? Some researchers argue that the central goal of the therapy process is to develop a secure attachment and strong therapeutic relationship with clients, especially with those who fall within the insecure category of attachment (Teyber & McClure, 2011). A secure attachment to one's therapist is considered to be a marker for concluding therapy for these clients rather than a point where therapy begins (Mallinckrodt, 2010).

In summary, the key areas of future research include:

- Replication of this research correcting limitations
- Attachment stability
- Can and should therapists present themselves as a blank slate?

5.6. Clinical Implications

If the research surrounding attachment and psychopathology discussed within the literature review of chapter 1 is to be considered, then therapists' attachment orientation impacts their interaction with others and their ability to manage life events. This emphasises the need for therapists to undergo their own therapy. Trainees are required to undergo thirty hours of therapy as pat of their training and depending on what it is they use therapy for, this may or may not be enough time. It is important for therapists to, therefore, review their own mental health to keep both their clients and themselves safe in line with ethical guidelines. Therapists are also susceptible to mental health difficulties as part of their occupation. It is not uncommon that therapists experience "compassion fatigue" (Weiss, 2004; Figley, 2002) as a result of the emotionally charged environment they work in (Mann, 2004) which ultimately leads to burnout (Rosenberg & Pace, 2006). This emphasises the necessity of supervision and self-care (Shapiro, Brown, & Biegel, 2007).

This study does not provide sufficient evidence for the measurement of attachment to be factored into the therapeutic process for the purpose of matching client and therapist based on attachment orientation to provide a better service and experience. However, this study and research included in chapter two reviewed many findings where insecure attachment was found to be associated with poor psychological outcomes, Therefore, having this insight allows therapists to consider what influence this may have on therapy. For example, considerations may involve what type of therapy to offer to a client. Avoidant clients may prefer online therapy and receive solution-focused therapy, which appeases their need to be independent. Anxious clients may prefer face-to-face person centred therapy as a result of their need to feel safe. Priorities,

preferences and the therapeutic 'ingredients' can be tailored to the individual attachment style to make the therapy more suited to the individual, personalised and therefore more efficacious.

The significance of client-perceived alliance found from this study, highlights findings by Bachelor (2013) in the discussion section of this chapter, that therapists would benefit from incorporating a measure of client alliance into the process of therapy as client views may differ to that of therapists. The benefits for the therapist include being able to modify any negatives clients report to improve the relationship and therefore therapeutic outcomes.

5.7. Concluding Summary

This study found that therapists with a secure attachment classification provided stronger therapeutic relationships and facilitated the greatest reduction in symptoms of depression. Moreover, the client's view of the relationship was the significant contributing variable to symptom reduction for depression. Finally, the results of this research saw a reduction in the severity of depression and anxiety overall, regardless of the client-therapist attachment dyads.

Not only has this research provided support to previous findings but it has also demonstrated the need to expand participant numbers and widen the measurement criteria and tools within the study to uncover whether attachment does impact the environment. An alternative might be that as a result of no significant attachment findings the argument might stand that it is, in fact, all down to the therapeutic environment that promotes changes in psychopathology.

Chapter 6 - CRITICAL REVIEW

6.1. Introduction

The following provides a critical reflection reviewing the research process, briefly using Gibbs (1988) reflective model. The rationale for the literature review is outlined followed by a reflection on the decisions made with regards to the empirical study. Therapeutic practice and clinical implications are discussed, and the impact on health services is suggested, concluding with potential opportunities for this research and considerations for research in the future.

6.2. Research question

The present research endeavoured to examine the interaction between client and therapist self-reported attachment styles and the impact of this interaction on the therapeutic relationship and client outcomes following the therapeutic process. Further, the research aimed to establish whether outcome improvement was the result of attachment style interaction or the therapeutic relationship.

6.3. Literature Review Rationale

As a lifespan theory, attachment can be argued to be embedded within our makeup regardless of whether we accept it as nature or nurture. Attachment, therefore, impacts biopsychosocial factors (Bartholomew & Shaver, 1998) and researchers have been investigating how, for many years now (Meredith, Stong, & Fenney, 2006). Eventually, this research reached exploration of variables within the therapeutic environment (Dozier, 1990) and therapeutic outcome (Catty, Winfield, & Clement 2007).

The approach taken for the literature review was carefully considered, and the author believed the best method was to evaluate every facet that places impact upon the research question. This approach was thought to make the review clearer as it can be argued that attachment is engrained within each aspect of the study. For example, a particular attachment style is at increased risk of psychopathology resulting in them attending therapy. Within the therapeutic environment is the therapist holding their own attachment style and the therapeutic relationship has been argued to be an attachment relationship in itself.

Difficulties regarding this method for reviewing existing literature include having solid boundaries. It would have been easy to include other information relevant to attachment and the influence in the therapeutic environment (such as personality factors), but this research did not measure in these particular areas. Therefore, it would have been irrelevant.

Alternative approaches to the literature review include a systematic approach. However, previous research in the same area has used this method and so the researcher preferred to undertake an alternative approach. In hindsight this approach would have provided both clarity and the boundaries needed to keep the review focused.

6.4. Empirical Study

6.4.1. Design

An advantage of the design of this study is its approach of measuring both client and therapist attachment styles and the opinion they both had of the therapeutic relationship. Not only is this in line with recommendations from previous literature (Norcross, 2002), it also prevents prospective bias. Furthermore, what makes this research relevant is the collection of client

outcomes at two-time points to identify any change. However, as much as this is an important aspect of the research, it is possible that prospective therapist participants felt too much was expected of them for the study, and it was too time consuming, or they agreed to take part but forgot to collect data from the sixth session of therapy.

The application of quantitative methods was deemed most suitable initially due to the comparison between groups from psychometric measures. However, it is possible that a dual perspective (quantitative and qualitative) may have been beneficial due to the small sample. However, the researcher was not aware of this until data was returned.

The main limitation of the design of the study was the recruitment element, which is explained in more detail below.

6.4.2. Recruitment

A limitation of the study was the recruitment of participants. Over 2000 therapists were approached with very little response. However, the focus behind this was to obtain a representative sample across the United Kingdom rather than focusing on a particular county or region. The lack of response may have been a result of therapists feeling exposed regarding their attachment style revealing something about them. Though, the preservation of anonymity endeavoured in every possible way. Therefore, it can be considered that only therapists who felt comfortable with their attachment style or had an interest in attachment agreed to take part. Furthermore, some of the therapists that agreed to take part may not have been able to recruit a client for the study.

6.4.3. Sample size

Former research within the area of the current research (Bruck, Winston, Aderholt, & Muran, 2006, Sauer, Lopez, & Gormley, 2003; Tyrell, Dozier, Teague, & Fallot, 1999) has had comparable sample sizes to the present study. However, an objective for this study was to exceed their sample size to establish any differences. 86 therapists agreed to take part, but only 39 returned the completed packs. Therefore the sample size was not an optimum quantity. The impact that a smaller sample size has upon the outcome of the study can be insignificant results. Field (2005) states that a small sample size can exaggerate the degree of a relationship leading to type II error. However it should be recognised that the sample size for this study is acceptable within the time restraints of data collection for the doctoral program.

6.5. Measures

6.5.1. Depression

The PHQ-9 (Kroenke, Spitzer & Williams, 2001) was used in this study to measure symptoms of depression pre and post therapy (session six). It is a short, standard clinical tool that can be used to monitor an increase or decrease in a client's depressive symptoms. Chronbach's alpha demonstrated strong internal consistency for both pre-study PHQ Questionnaire (r = .885) and post-study PHQ Questionnaire (r = .869). This tool was selected because it allowed the researcher to identify the severity of depressive symptoms upon the commencement of therapy as well as the clients' response to therapy. This was identified via changes in the severity of symptoms. This tool was sufficient for the requirements of this study and would be used again if the researcher were to replicate the study.

6.5.2. Anxiety

The GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006) was used in this study to measure symptoms of anxiety pre and post therapy (session six). Similar to the PHQ-9, the GAD-7 is a short, standard clinical tool that can be used to monitor an increase or decrease in a client's symptoms of anxiety. Chronbach's alpha also demonstrated strong internal consistency for both pre-study GAD-7 (r = .905) and post-study GAD-7 (r = .893). Like the PHQ-9, the GAD-7 was selected because it allowed the researcher to identify symptoms of anxiety upon the commencement of therapy as well as the clients' response to therapy. This was identified via changes in the severity of symptoms. This tool was sufficient for the requirements of this study and would be used again if the researcher were to replicate the study.

6.5.3. Attachment

Upon commencing the research, the author was confident that the study should measure attachment from a general perspective rather than from a romantic perspective or childhood perspective, like interpersonal relationships and affect regulation in adults are manifested from the attachment development with our caregivers (Wei, 2008). Therapy with adults focuses on modifying current ineffective coping strategies (Wei, 2008). Therefore the researcher believed it was important to assess ones current style of attachment consequently to focus on interpersonal functioning as an adult (Difilippo & Overholster, 2002).

To continue with a design that was brief and within quantitative methods, a self-report measure of attachment was chosen. Narrative methods such as the AAI (Adult Attachment Interview; Main, Kaplan & Cassidy, 1985) are time-consuming, qualitative in design and require a researcher to be trained to administer the interview. Further to this, the AAI was unsuitable for

this study as attachment is categorised based on an individual's memories of their attachment experiences. This method has been suggested to exclude information relating to an individual's internal working model (e.g. conscious emotions, thoughts and behaviours; Difilippo & Overholster, 2002)

The ECR-RS (experience in close relationships – relationship structures questionnaire; Fraley, Heffernan, Vicary, & Brumbaugh, 2011) is an adaptation of the ECR (Brennan, Clark, & Shaver's, 1998) and ECR-R (Fraley, Waller, and Brennan, 2000) both of which were devised from one of the earliest self-report attachment measures the Relationship Questionnaire (RQ) by Bartholomew & Horowitz (1991), which was restricted to only one question for each style of attachment. The ECR-RS, unlike its predecessors, evaluates patterns of attachment in a variety of close relationships (not just romantic relationships). The attachments to four interpersonal targets (i.e., mother, father, romantic partner, and best friend) are assessed using the same nine items that link with the integral elements of attachment, safe have, secure base. It can be argued that friends are not attachment figures, however, the scale is not exhaustive or limited to the targets described above and can be used for anyone who possesses features of the attachment system such as a secure base or safe haven. Across these nine items are two subscales, one, which measures attachment, related avoidance (items 1-6) and the other attachment-related anxiety (items 7-9). It was used in this study to obtain the client and therapist's general style of attachment. This is achieved by averaging the total score of each subscale for each target. Since commencing this study the wording and scoring information of the global target for ECR-RS have been modified to unequivocally target an individual's general style of attachment. This new method avoids a literal, linear combination of the relationship-specific measures, which made it difficult to study how relationship-specific and general representations might change together.

Within the new approach, nine separate items have been created, and new instructions advise individuals to "Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships in general." Nine items that are worded comparable in theme for those used to assess relationship-specific attachment then follow this. Scoring is similar in that the first six items measure avoidance related attachment patterns (1-4 reversed scored) and the last three items measure anxiety related attachment patterns. An example of a newly worded item includes 'I prefer not to show others how I feel deep down' compared with the comparable item used within the previous version (and this study) 'I prefer not to show this person how I feel deep down'. Using this new method would have been more appropriate for the study. Firstly, administration would have been less time consuming, as both client and therapist would have only needed to answer the 'new' nine items therefore also reducing any confusion with regards to instructions. Secondly, participants need not be reminded how relationships are/were with specific targets, therefore, reducing any possible distress as a result. Finally, scoring and analysis would be less complicated and time consuming as the process would only need completing once rather than several times. This new approach for obtaining a global attachment orientation would have been much preferred and would be used for any future research.

6.5.4. Therapeutic Relationship

The HAQ-II (Revised Helping Alliance Questionnaire; Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, & Daley, 1996) was used in this study to obtain perspectives from both the client and therapist on their interpretation of the therapeutic alliance. This allowed correlations to be made to attachment style to identify whether particular styles of attachment viewed the

relationship more favourably than another. Previous research has implemented the WAI (Working Alliance Inventory) and the CALPAS (The California Psychotherapy Alliance Scale; Gaston, 1991) and all are used proportionately (IsHak, Burt, & Sederer, 2002). However, the HAQ-II was implemented in this study as the client's score corresponds to their satisfaction of therapy rather than the reduction in symptoms of a disorder (symptomatic improvement). This element was measured using the PHQ-9 and GAD-7 as detailed above. Therefore the HAQ-II was deemed the most suitable. It could be argued that the use of different therapeutic alliance measure (measuring symptomatic improvement) would eradicate the need for the PHQ- 9 and GAD-7 making the study less time consuming, however, the measure is unlikely to provide construct validity for anxiety and depressive symptoms that are provided by the GAD-7 & PHQ-9.

6.6. Procedure

Therapist participants were required to select a client attending their first session of therapy, asking them to complete measures at this session and the sixth session. This method was implemented due to previous research revealing that the therapeutic relationship is established within the first three sessions of therapy (Ligiero & Gelso, 2002). There are several implications of this method. Firstly, private therapists were recruited and may have had a full caseload leading to them declining participation or having to wait until they had space to take on a new client. Secondly, if a therapist took on a new client presenting an opportunity to participate in the study there is no guarantee that the client would agree to take part and therefore the therapist may then have to wait until they had availability again. Finally, client's who agreed to take part may not have reached six sessions of therapy either through drop out or needing less than six sessions.

However, the aim of this process was to eliminate selection bias as clients are selected by their attendance to their first session rather than their probability of saying yes to participation or having formed some form of relationship with the client already which would impact therapeutic relationship scores. Though the research does not stipulate the exclusion of clients that have previously received therapy from the participating therapist, which is not unreasonable to conceive.

6.7. Analysis

Normality was assessed for each measure using the Kolmogorov-Smirnov statistic before conducting data analysis. Field (2005) recommended values of Skewness and kurtosis to fall within +/- 1.96 standard errors. These values were examined, and considered acceptable based on Field's recommendation. Following this, the reliability and validity of variables were assessed, and all measures were considered to be valid measures.

Frequencies, descriptive statistics and correlations were conducted to determine general findings from the data. Following this regression analysis was performed to identify whether client and therapist attachment predicted any variance in the therapeutic relationship and therapeutic outcomes.

It is possible that this study would have benefitted from a qualitative approach as questionnaires can result in response bias (discussed in research process reflection section)

6.8. Implications For Practice

The implications of attachment within therapeutic practice have emerged in recent decades (Mallinckrodt, 2000; Lopez & Brennan, 2000; Cassidy & Shaver, 2010; Lopez, 1995). Attachment theory is a model of interpersonal relationships and affect regulation. It functions as a concrete base for which ineffective coping strategies can be understood and the dynamics that motivate an individual's emotional difficulties. Clinicians can bring this into a client's awareness and assist them into altering their ineffective coping strategies. Furthermore, therapists can support clients in obtaining understanding around their unmet needs that find fulfilment in the ineffective coping strategies and facilitate them in acquiring new ways that satisfy their emotional and psychological desires (Wei, 2008).

Therapists who are aware of their client's pattern of attachment (i.e. avoidant or anxious) will be better able to tailor interventions accordingly to modify coping strategies. As different attachment patterns are likely to use different coping mechanisms to manage their emotional and psychological difficulties (Wei, 2008). For example, individuals with attachment anxiety are more likely to exaggerate negative feelings as a coping mechanism, which is associated with a negative view of oneself. Wei, Ku, & Liao (2007) found that increasing their self-compassion could enhance their wellbeing.

Counselling psychologists are subject to personal therapy as part of their training however it is not mandatory after the thirty-hour requirement and is not compulsory for other professionals offering a therapeutic service. Therapy could provide clinicians with awareness of their own ineffective coping strategies and the dynamics that motivate their emotional difficulties. Furthermore, it will make therapists mindful of how they respond to others and

therefore their clients. This may provide therapists with the ability to adapt accordingly depending on their client's attachment style.

If a therapist's attachment style was assessed as part of routine clinical practice, it is possible that clients could be matched to their corresponding therapist based on their attachment orientations. For example clients with and avoidant attachment, status would be matched with therapists who would focus on acceptance and explore their emotions (Bernier, Larose, & Soucy, 2005). Though, findings were not significant therefore do not warrant this process based on this study alone.

This concept, however, does extend further to include clinical supervision. It can be contended that the therapeutic relationship between a supervisor and their supervisee may function in a similar way to that of client and therapist. Therefore, a supervisee who is dismissive of the support provided by their supervisor reduces the emotional factors within the relationship and deactivates their attachment needs. This supervisee may generate a better alliance with a less dismissive supervisor. In contrast, supervisee's who are anxious in their attachment orientation may be too reliant on their supervisor and develop enhanced relationships with opposing styles of attachment. The use of attachment questionnaires in this sector would result in the supervisee obtaining the most out of their supervision thus enhancing client work.

A final consideration of the clinical implications of attachment assessment within therapeutic practice is the use of attachment questionnaires to measure outcome. Depending on a therapist's belief or theoretical orientation some may deem the aim of therapy is the revision of a client's internal working model (Davila & Levy, 2006). In this instance, attachment orientation may be a primary goal for therapy. However, this does not come without its complications. Factoring in attachment questionnaires may impede on time allocated to therapy sessions and on

the therapist's time following the session to identify attachment orientation. Also, Eagle (2006) acknowledged that there might be some danger in categorising clients with regards to their attachment style.

6.9. Future Research

6.9.1. Promoting Current Study

To maintain CPD (continued professional development) the next step for this research will be to publish the findings in the Journal of Counselling Psychology and disseminate them to practitioners, starting with those who took part in the study. Private practitioners are in control of their practice, therefore implementing attachment related practice is much more feasible in this area. Findings illustrate the significance of client-perceived alliance, therefore, implementing a client alliance measure would be the consideration for therapists as a result of this study.

Implementing workshops within services around the significance of attachment and the use of measuring client attachment to inform the approach of the therapeutic process in terms of tailoring interventions. Furthermore, contacting DCoP and enquiring whether a workshop could be administered at the next conference would target a large proportion of the professional population.

In addition, encouraging the use of attachment measures at the beginning of therapy will provide insight into the client's history. For example a client with an anxious style of attachment will have had an inconsistent experience of care and informs the therapist that the client is likely to view the world as unpredictable and themselves as not good enough. This information allows the therapist some insight without having to read the client's complete history (if available) and doesn't have to 'dig' so much in the initial stages. The therapist will know how to approach the

client in the sessions leading to a stronger rapport ultimately enhancing the therapeutic process as a whole.

Becoming aware of the therapists own attachment style during personal therapy or supervision will provide the therapist insight into both themselves and how they function within the therapeutic process. For example, transference.

6.9.2. Replicating Current Study & New Research Ideas

Improvements for this study include obtaining more participants. Providing client and therapist with unique username and passwords and asking them to complete the questionnaires through an online survey might achieve this. This method would reduce therapist responsibility and the time inhibited on the therapy session. This would also reduce administration time for the researcher, fulfil data storage security and reduce the time spent inputting data. Targeting NHS trusts in addition to or as opposed to private clients may result in greater participation. Using the improved global attachment measure of the ECR-RS will again decrease the time it takes to complete the questionnaire, reduce participant distress, and may also reflect different results due to the new item wordings. Finally, expanding the research design process so that measures are collected at the beginning and end of therapy instead of session six may provide an in-depth view of the impact of the therapeutic relationship. Introducing the attachment questionnaire for the client to the final session would also highlight whether there has been a shift in attachment orientation as a result of therapy.

A final thought for future research might be to address whether therapist attachment styles change during counselling psychology training. Trainees are required to attend therapy as part of training in addition to taking part in several years of personal development. If a trainees'

attachment style changes through their training what impact does this have on the clients they see during this training?

6.10. Research Process Reflection

6.10.1. Research Bias

As discussed previously, there may have been some element of measurement and response bias from therapist participants as they may have answered the attachment questionnaire in a way that displays their favoured style of attachment. It is unlikely for client participants to respond in a similar fashion, as they would be less likely to know how the questionnaire is scored.

Client participants may not have answered the HAQ-II questionnaire truthfully as they may not want to show their therapist their true opinions of the relationship. This is unlikely to occur for therapist participants, as client participants are highly unlikely to see their therapist's answers to the questionnaire, unlike client participants, whose questionnaires are kept by their therapist to return to the researcher. Although the therapist should not intentionally look at their client's questionnaires, there were no stipulations against this in the research instructions and there was limited control over this in the current design. A way around this, if replicated, would be to implement an electronic version of the questionnaire through a unique username and password.

6.10.2. Researcher's Journey

The research topic was chosen out of interest in the differences individuals have toward their interpersonal relationships and the origin of this. Attachment is a concept that begins at the earliest time point in one's lifespan, therefore, was considered the most appropriate theory.

Following this, the researcher had to apply this concept to counselling psychology and turned to her own therapeutic work to find inspiration. She has often wondered why some clients are extremely easy to work with, and others are challenging. She questioned, as a result, whether it had anything to do with personality and what link this may have with attachment and began to search the literature. It appeared research on personality in the therapeutic environment was vast, so this element was withdrawn. Attachment within the therapeutic environment focused largely on the client and not the therapist. Through repeated investigation on existing studies of attachment in the therapeutic environment the researcher began to form some research questions surrounding the compatibility of attachment styles and thus, this research concept was produced.

Initially, the research was intended to contact both primary and secondary NHS trusts. However, very little response from the research and development departments within the NHS sites regarding research approval meant the researcher was unable to continue with the recruitment of participants from NHS trusts. Therefore, the researcher had to approach participants via an alternative avenue if the study was to meet the specified deadline. This was disheartening in such early stages of the research process and resulted in additional work as the research packs had to be amended to apply to private therapists as opposed to NHS therapists. With the hope of gaining a large sample, all therapists on the BPS and EMDR website were contacted. This could have been extended to include therapists listed on the BACP website but time was limited.

The process of this research has encouraged the author to think methodically with regards to cause and effect of every possible decision that could be made and its outcome. However, nothing is perfect; improvements can always be made but sometimes they are not always predictable, and decisions have to be carried out to observe the outcome before alterations can be

implemented. Also, the researcher has perfected their ability to manage time and meet their own deadlines.

As a practitioner, the research encourages the author to consider the role of one's attachment style in their everyday functioning and interpersonal interactions. This can assist in tailoring interventions accordingly. Completing this study has also inspired the researcher to inform other professionals of the importance of attachment within therapeutic work. This has further expanded to include the desire to offer workshops of important topics to certain client groups to instil awareness. Without completing this research the researcher believes their confidence levels would have prevented this from happening.

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APPENDICES

Appendix 1

DATE: _____

VERSION NO: 1

Invite Letter to Psychologist Participant

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

Dear Sir/Madam

As part of my Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton, I am conducting research that explores attachment styles of client and therapist and the effect they have on therapeutic outcomes and alliance. To do this I would require your support by participating in the study.

This study aims to investigate the attachment style combinations of clients and therapists and if some are more compatible than others. This will be measured by therapeutic outcomes and the strength of the alliance.

To do this, it requires you (the therapist) to provide the researcher with data from IAPT measures given to your client and provide some additional questionnaires to your client at session 1 and session 6 of therapy. It also requires you to complete a questionnaire at session 1 and session 6 of therapy, which will take no more than ten minutes of your time in total. The additional questionnaires for your client will take no more than ten minutes of their time to complete at session 1 of therapy and ten minutes of your time at session 6.

The potential benefits of this research include contributions to the field of counseling psychology by providing insight to both clients and therapists about which relationships can provide better therapeutic outcomes. This may lead to less time spent in therapy and less drop out rates.

I am therefore writing to ask whether you would be interested in taking part in this study. I enclose a detailed information sheet, which explains the aims of the project and what taking part will involve.

Yours Sincerely

Jennifer Beaumont

Trainee Counselling Psychologist

University of Wolverhampton Jennifer.beaumont@wlv.ac.uk

Appendix 2

DATE: _____

VERSION NO: 1

PRACTITIONER INFORMATION SHEET

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

You are being invited to take part in a research study. Before you decide it is important that you to understand why the research is being done and what it will involve. Please read the following information carefully and ask if anything is unclear or would like more information. Take time to decide whether you wish to take part or not. Thank you for reading this.

What is the purpose of the study?

This study is interested in the attachment style combinations of clients and therapists and if some are more compatible than others. This will be measured by therapeutic outcome measures and the strength of the alliance.

Completion of this research will mean clients and professionals can be matched based on their attachment style which in turn would be of benefit to both parties.

This research project is part of the requirement of the Practitioner Doctorate in Counselling Psychology course, at the University of Wolverhampton.

Why have I been chosen?

You have been chosen because your qualifications meet the requirements of the study and the researcher has accessed your details via the BPS chartered psychologist directory.

Do I have to take part?

No, you are not obligated to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are free to withdraw at any time up until the data analysis commences and you are not required to provide a reason for your withdrawal.

What will happen if I decide to take part?

The researcher will provide you with an instruction pack that asks you to recruit 1 of your clients as part of the research. You will be asked to complete 2 questionnaires in total but at different times and you will be asked to provide your client with several questionnaires. Clients must be receiving CBT, EMDR or Person Centered therapy (can be integrative) for anxiety or depression (can be co-morbid)

What are the potential benefits and risks of taking part?

The study aims to benefit psychologists and clients by informing them that specific relationships in therapy may provide better outcomes. This could lead to fewer dropouts and less therapy sessions.

The potential risks include heightened emotions due to thinking about relationships you have with others. The same applies to your clients and they have been advised to discuss this with you in therapy should this occur.

Will my taking part in the study be kept confidential?

Yes absolutely. All the information regarding your participation in this study will be kept confidential. All data will be coded so no one can be identified and will also be kept in a password protected file and computer that can only be accessed by the researcher. The data will be stored for 5 years and then destroyed confidentially. Only the researchers working on the project will have access to the information, which will be unidentifiable. You will not be recognizable in any publication or report as the data will be numerical and any identifying information will be removed.

What will happen at the end of the research study?

A doctoral thesis will be produced and a summary of the thesis can be obtained should you request it.

What if I have a problem or concern?

If you have any concerns about any aspect of this research, you should contact the researcher or the research supervisors who will do their best to answer your questions. Contact details of supervisory team:

1st Supervisor – Wendy Nicholls, Wendy.Nicholls@wlv.ac.uk, 01902 3211359

2nd Supervisor – Abigail Taiwo, A.Taiwo@wlv.ac.uk, 01902 3211346

Who has reviewed the study?

The Research Ethics Committee in the Faculty of Education, Health and Wellbeing of the University of Wolverhampton and the Research Ethics Committee for the NHS West Midlands region have reviewed this study. If you would like more information about this, please feel free to contact the research supervisors.

Contact for further information

If you have any questions or would like further information about this research, please contact the researcher:

Jennifer Beaumont

Trainee Counselling psychologist

Jennifer.beaumont@wlv.ac.uk

I would like to thank you for your participation in this study. Your involvement will make significant contributions to this study and offer potential developments in research for this field.

* Please retain this participation Information sheet and proceed to sign the consent form giving your permission to take part in the study.

Appendix 3

Psychologist instruction Pack

Dear Psychologist

This study is looking into the attachment style combinations of clients and therapists and their effect on therapeutic outcome. In addition the therapeutic relationship will be measured in order to determine its significance in relation to attachment style combinations. This research will provide information that is of benefit to both the client and the professionals involved

This research project is part of the requirement of the PsychD in Counselling Psychology course, at the University of Wolverhampton.

Thank you for taking part. This should take no more than 10 minutes of your valuable time.

Explanation of this therapist pack.

1. Please sign the **'therapist consent'** form, to agree to take part in this research and complete the '**therapist personal details'** form and **'attachment questionnaire'** about yourself (complete only once).

2. Select one of your NEW clients, who are attending their **1st session** of therapy for anxiety or depression (this may include anxiety or depression as a result of other difficulties i.e. PTSD) and would be happy to complete 2 short question sheets. (Excluding clients in crisis, or those not literate in English).
3. Please ask each client to sign a '**client consent'** form and retain this yourself.
4. Hand your client the '**attachment questionnaire'** form. Assure them this is completely anonymous, as it does not identify them, or their therapist, personally.
5. In addition, would you provide the trainee psychologist with IAPT outcome measures from **session 1.**
6. At **session 6** please ask your client to complete the **'IAPT measures'** and **'therapeutic relationship questionnaire'**.
7. Complete the **'therapeutic relationship questionnaire'** yourself and send the following forms back to researcher:

- Your consent / personal details form
- Your attachment questionnaire
- Your therapeutic relationship questionnaire
- Client consent / personal details forms
- Client IAPT outcome measures (session 1 & 6)
- Client attachment questionnaire
- Client therapeutic relationship questionnaire

Thank you very much for your time and input into this research. A copy of the results will be made available to you on completion should you wish.

Yours Sincerely

Jennifer Beaumont

Trainee Counselling psychologist

Jennifer.beaumont@wlv.ac.uk

Supervised by Dr Wendy Nicholls

Appendix 4

DATE: _____

Completely Confidential T number:

PRACTITIONER CONSENT FORM

Title of Project: The impact of client and therapist attachment styles on therapeutic outcomes

Name of Researcher: Jennifer Beaumont

Please Initial

☐ I have read and understood the details provided on the psychologist' letter.

☐ I understand this research is completely confidential & voluntary and no individual will be identified.

☐ I understand that this research may later be used for presentation, or publication purposes and that I may have access to the finished report via the trainee psychologist who handed this to me.

☐ I understand that I am free to ask questions at any time and I may withdraw my consent to take part at any time, without having to give a reason why.

☐

I understand that all data from this project will be handled in accordance with the BPS code of ethics. *

☐ I agree to take part in this research.

Signed .....**Dated** .....

* Code of Ethics can be obtained from the BPS (0116 254 9568), or from the University of Wolverhampton (01902 321100).

Appendix 5

Completely Confidential T number:

Therapist Personal Details:

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

Please tick

1. Profession? Clinical Psychologist o Counselling Psychologist o

Chartered Psychologist o

2. Work Place? Psychology Department o Multi-disciplinary team o

Health centre o In-patients department o

Other? Please state.....

3. Gender? Male o Female o

4. Age? <25yrs o 26-35yrs o 36-45yrs o 46-55yrs o >55yrso

5. Ethnicity? White o Asian o Afro-Caribbean o

Other? Please state .....

6. Are you a trainee? Yes o No o

7. How many years in practice? <2yrs o 2-5yrs o 6-10yrs o 11yrs+o

8. **What is your primary theoretical orientation?** Please give brief details

.....

Thank you.

Appendix 6

T number:

Completely Confidential P number:

Relationship Structures Questionnaire (Attachment Questionnaire)

The Relationship Structures Questionnaire (ECR-RS) is a questionnaire designed to assess attachment patterns in a variety of close relationships for example mother (or a mother-like figure), father (or a father-like figure), current (or a former) romantic partner, and best friend (or close friends more generally). With adaptations, the statements are also relevant to therapeutic relationships.

The statements below are about how you feel in emotionally intimate relationships. You can use them to assess how you tend to feel in close relationships generally, or to focus on a particular relationship or type of relationship. Using the 1 to 7 scale below, after each statement write a number to indicate how much you agree or disagree with the statement.

A. Please answer the following questions about your mother or a mother-like figure.

B. Please answer the following questions about your father or a father-like figure.

C. Please answer the following questions about your dating or marital partner.

Note: If you are not currently in a dating or marital relationship with someone, answer these questions with respect to a former partner or a relationship that you would like to have with someone.

D. Please answer the following questions about your best friend.

1 2 3 4 5 6 7

Strongly Disagree ***Strongly Agree***

In the questionnaire, “m” is for mother, “fa” for father, “p” for partner, “fr” for friend

		M	Fa	P	Fr
1	**It helps to turn to this person in times of need**				
2	**I usually discuss my problems and concerns with this person**				
3	**I talk things over with this person**				
4	**I find it easy to depend on this person**				
5	**I don't feel comfortable opening up to this person**				
6	**I prefer not to show this person how I feel deep down.**				
7	**I often worry that this person doesn't really care for me**				
8	**I'm afraid that this person may abandon me**				
9	**I worry that this person won't care about me as much as I care about him or her**				

Fraley, R., Heffernan, M., et al (2011). The Experiences in Close Relationships-Relationshi

A method for assessing attachment orientations across relationships. Psychological Assessm

DATE: _____

VERSION NO: 1

Appendix 7

Invite Letter to Client Participant

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

Dear Sir/Madam

As part of my Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton, I am conducting research that explores therapeutic outcomes based on the connections between clients and their therapists. To do this I would require your support by participating in the study.

This study aims to investigate the attachment styles of clients and therapists and if they impact the outcome of therapy and upon the therapeutic relationship. To do this it requires you (the client) to complete some additional questionnaires to those your therapist has already asked you to complete. The additional questionnaires will take no more than ten minutes of your time to complete at session 1 of therapy and ten minutes of your time at session 6.

The potential benefits of this research include contributions to the field of counseling psychology by providing insight to both clients and therapists about which relationships can provide better therapeutic outcomes. This may lead to less time spent in therapy and less drop out rates.

I am therefore writing to ask whether you would be interested in taking part in this study. I enclose a detailed information sheet, which explains the aims of the project and what taking part

will involve. If you feel that you would like to be involved or would like to know more information about this research please get in touch with me using the contact details below.

Yours Sincerely

Jennifer Beaumont

Trainee Counselling Psychologist

University of Wolverhampton

Jennifer.beaumont@wlv.ac.uk

DATE: _____

VERSION NO: 1

Appendix 8

CLIENT INFORMATION SHEET

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

You are being invited to take part in a research study. Before you decide it is important that you to understand why the research is being done and what it will involve. Please read the following information carefully and ask if anything is unclear or would like more information. Take time to decide whether you wish to take part or not. Thank you for reading this.

What is the purpose of the study?

This study is interested in the connections we have with other people that are determined from birth onwards and it is known also as attachment. There are four different styles within attachment and this research is interested in the attachment style of a client and their therapist and whether different attachment styles are more suited than others, which may therefore affect the outcome of therapy.

Completion of this research will mean clients and professionals can be matched based on their attachment style which in turn would be of benefit to both parties.

This research project is part of the requirement of the Practitioner Doctorate in Counselling Psychology course, at the University of Wolverhampton.

Why have I been chosen?

You have been chosen randomly by your psychologist based on these factors:

You are aged 18-65

You are starting your 1st session of therapy

You are seeking therapy because your mood is low and/or you sometimes feel anxious.

Do I have to take part?

No, you are not obligated to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are free to withdraw at any time up until the data analysis commences and you are not required to provide a reason for your withdrawal.

What will happen if I decide to take part?

Your psychologist will ask you to complete some questionnaires at your first therapy session and again at your sixth therapy session. You will not be asked to provide any information that will make you recognisable.

What are the potential benefits and risks of taking part?

The study aims to benefit psychologists and clients by informing them that specific relationships in therapy may provide better outcomes. This could lead to fewer dropouts and less therapy sessions.

The potential risks include heightened emotions due to thinking about relationships you have with others. You should discuss this with your therapist should this occur.

Will my taking part in the study be kept confidential?

Yes absolutely. All the information regarding your participation in this study will be kept confidential. All data will be coded so no one can be identified and will also be kept in a password protected file and computer that can only be accessed by the researcher. The data will be stored for 5 years and then destroyed confidentially. Only the researchers working on the project will have access to the information, which will be unidentifiable. You will not be recognizable in any publication or report as the data will be numerical and any identifying information will be removed.

What will happen at the end of the research study?

A doctoral thesis will be produced and a summary of the thesis can be obtained should you request it.

What if I have a problem or concern?

If you have any concerns about any aspect of this research, you should speak with you're psychologist, contact the researcher or the research supervisors who will do their best to answer your questions. Contact details of supervisory team:

1st Supervisor – Wendy Nicholls, Wendy.Nicholls@wlv.ac.uk, 01902 3211359

2nd Supervisor – Abigail Taiwo, A.Taiwo@wlv.ac.uk, 01902 3211346

Who has reviewed the study?

The Research Ethics Committee in the Faculty of Education, Health and Wellbeing of the University of Wolverhampton and the Research Ethics Committee for the NHS West Midlands region have reviewed this study. If you would like more information about this, please feel free to contact the research supervisors.

Contact for further information

If you have any questions or would like further information about this research, please contact the researcher:

Jennifer Beaumont

Trainee Counselling psychologist

Jennifer.beaumont@wlv.ac.uk

I would like to thank you for your participation in this study. Your involvement will make significant contributions to this study and offer potential developments in research for this field.

* Please retain this participation Information sheet and proceed to sign the consent form giving your permission to take part in the study.

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

DATE: _____

Appendix 9

VERSION NO: 1

Completely Confidential P number:

CLIENT CONSENT FORM

Title of Project: The impact of client and therapist attachment styles on therapeutic outcomes

Name of Researcher: Jennifer Beaumont

Please initial

☐ I understand that I will be asked to fill out a questionnaire to determine my attachment style.

☐ I understand that the psychological questionnaires I completed at the beginning and session 6 of therapy will be used for this study.

☐ I have read and understood the information provided.

☐ I understand this research is completely confidential & voluntary and

no individual will be identified.

☐ I understand that this research may later be used for presentation, or publication purposes and that I may have access to the finished report via the researcher.

☐ I understand that I am free to ask questions at any time and I may withdraw my consent to take part at any time, without having to give a reason why.

☐ I understand that all data from this project will be handled in accordance with the BPS code of ethics*.

☐ I consent to take part in this research.

Signed.....**Dated**.....

- Code of Ethics can be obtained from the BPS (0116 254 9568), or from the University of Wolverhampton (01902 321100).

Appendix 10

Completely Confidential P number:

Client Personal Details:

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

Please tick

1. **Gender?** Male O Female O

2. **Age?** <25yrs O 26-35yrs O 36-45yrs O 46-55yrs O >55yrsO

3. **Ethnicity?** White O Asian O Afro-Caribbean O

Other? Please state .....

4. **Relationship Status?** Married O Single O Divorced O

Widowed O Co-habiting O

5. **Sexual Orientation?** Heterosexual O Gay O Bisexual O Prefer not to comment O

6. **Children?** Yes O No O

7. **Have you received counselling before?** Yes O No O

8. **What are you receiving counselling for?** Anxiety O Depression O Both O

Thank you.

Appendix 11

Completely Confidential

P number:

PHQ- 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 total score

Appendix12

Completely Confidential

P number:

GAD7

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 total score

Appendix 13

T number:

Completely Confidential P number:

Relationship Structures Questionnaire

The Relationship Structures Questionnaire (ECR-RS) is a questionnaire designed to assess attachment patterns in a variety of close relationships for example mother (or a mother-like figure), father (or a father-like figure), current (or a former) romantic partner, and best friend (or close friends more generally). With adaptations, the statements are also relevant to therapeutic relationships.

The statements below are about how you feel in emotionally intimate relationships. You can use them to assess how you tend to feel in close relationships generally, or to focus on a particular relationship or type of relationship. Using the 1 to 7 scale below, after each statement write a number to indicate how much you agree or disagree with the statement.

A. Please answer the following questions about your mother or a mother-like figure.

B. Please answer the following questions about your father or a father-like figure.

C. Please answer the following questions about your dating or marital partner.

Note: If you are not currently in a dating or marital relationship with someone, answer these questions with respect to a former partner or a relationship that you would like to have with someone.

D. Please answer the following questions about your best friend.

1 2 3 4 5 6 7

Strongly Disagree ***Strongly Agree***

In the questionnaire, “m” is for mother, “fa” for father, “p” for partner, “fr” for friend

		M	Fa	P	Fr
1	**It helps to turn to this person in times of need**				
2	**I usually discuss my problems and concerns with this person**				
3	**I talk things over with this person**				
4	**I find it easy to depend on this person**				
5	**I don't feel comfortable opening up to this person**				
6	**I prefer not to show this person how I feel deep down.**				
7	**I often worry that this person doesn't really care for me**				
8	**I'm afraid that this person may abandon me**				
9	**I worry that this person won't care about me as much as I care about him or her**				

Fraley, R., Heffernan, M., et al (2011). The Experiences in Close Relationships-Relationship Structures questionnaire: A method for assessing attachment orientations across relationships. Psychological Assessment, 23, 615-625.

Appendix 14

THE HELPING ALLIANCE QUESTIONNAIRE
Therapist Version

INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your patient, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
1. The patient feels he/she can depend upon me.	1	2	3	4	5	6
2. He/she feels I understand him/her.	1	2	3	4	5	6
3. The patient feels I want him/her to achieve the goals.	1	2	3	4	5	6
4. At times the patient distrusts my judgment.	1	2	3	4	5	6
5. The patient feels he/she is working together with me in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of his/her problems.	1	2	3	4	5	6
7. The patient generally respects my views about him/her.	1	2	3	4	5	6
8. The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	1	2	3	4	5	6
9. The patient likes me as a person.	1	2	3	4	5	6
10. In most sessions, we find a way to work on his/her problems together.	1	2	3	4	5	6
11. The patient believes I relate to him/her in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12. The patient believes a good relationship has formed between us.	1	2	3	4	5	6
13. The patient believes I am experienced in helping people.	1	2	3	4	5	6
14. I want very much for the patient to work out his/her problems.	1	2	3	4	5	6
15. The patient and I have meaningful exchanges.	1	2	3	4	5	6
16. The patient and I sometimes have unprofitable exchanges.	1	2	3	4	5	6
17. From time to time, we both talk about the same important events in his/her past.	1	2	3	4	5	6
18. The patient believes I like him/her as a person.	1	2	3	4	5	6
19. At times the patient sees me as distant.	1	2	3	4	5	6

Appendix 15

THE HELPING ALLIANCE QUESTIONNAIRE
Patient Version

INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
1. I feel I can depend upon the therapist.	1	2	3	4	5	6
2. I feel the therapist understands me.	1	2	3	4	5	6
3. I feel the therapist wants me to achieve my goals.	1	2	3	4	5	6
4. At times I distrust the therapist's judgment.	1	2	3	4	5	6
5. I feel I am working together with the therapist in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of my problems.	1	2	3	4	5	6
7. I generally respect the therapist's views about me.	1	2	3	4	5	6
8. The procedures used in my therapy are not well suited to my needs.	1	2	3	4	5	6
9. I like the therapist as a person.	1	2	3	4	5	6
10. In most sessions, the therapist and I find a way to work on my problems together.	1	2	3	4	5	6
11. The therapist relates to me in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12. A good relationship has formed with my therapist.	1	2	3	4	5	6
13. The therapist appears to be experienced in helping people.	1	2	3	4	5	6
14. I want very much to work out my problems.	1	2	3	4	5	6
15. The therapist and I have meaningful exchanges.	1	2	3	4	5	6
16. The therapist and I sometimes have unprofitable exchanges.	1	2	3	4	5	6
17. From time to time, we both talk about the same important events in my past.	1	2	3	4	5	6
18. I believe the therapist likes me as a person.	1	2	3	4	5	6
19. At times the therapist seems distant.	1	2	3	4	5	6

Appendix 16

Participant Debrief

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

Thank you for taking part in this research study. The aim of this research is to determine if there is a connection between attachment style combinations of therapist and client and therapeutic outcomes. In addition this will reveal which attachment style combinations are most compatible. The research will serve to benefit therapists and clients. If clients and therapists are paired based on compatible attachment style combinations, it could reduce the amount of sessions clients need and reduce the amount of dropouts.

Thanks again for your time and participation. If you would like to receive a copy of the research findings, please do not hesitate to get in touch.

Jennifer Beaumont

Trainee counselling psychologist

Jennifer.beaumont@wlv.ac.uk

Appendix 17

Notification to Client's GP

The impact of client and therapist attachment styles on therapeutic outcomes

Jennifer Beaumont

Trainee Counselling Psychologist

Dear Dr

Re:_____, D.O.B _____

I am writing to inform you that your above patient is taking part in a research study that I am conducting as part of the practitioner doctorate in counselling psychology at the University of Wolverhampton.

Joe Bloggs should not suffer any psychological distress from taking part and any distress that may be caused will be dealt with during therapy with the patient's psychologist.

Should you have any questions please do not hesitate to contact the research supervisors or myself.

Yours Sincerely

Jennifer Beaumont

Trainee counselling psychologist

Jennifer.beaumont@wlv.ac.uk

1st Supervisor – Wendy Nicholls, Wendy.Nicholls@wlv.ac.uk, 01902 3211359

2nd Supervisor – Abigail Taiwo, A.Taiwo@wlv.ac.uk, 01902 3211346

Appendix 18

Reliability and Validity Analysis

Cronbach's alpha demonstrated strong internal consistency on the following scales: pre-study PHQ Questionnaire (r = .885), post-study PHQ Questionnaire (r = .869), pre-study GAD-7 (r = .905), post-study GAD-7 (r = .893), therapist helping alliance questionnaire (THA) (r = .94), client helping alliance questionnaire (CHA) = .921, therapist attachment questionnaire (r = .916), and the client attachment questionnaire (r = .957). Factor validity was used to assess the measures mentioned above, and measures were found to perform satisfactorily. Factor validity was assessed using principle components analysis with Varimax rotation. The pre-and post-study PHQ and GAD-7 items were combined for the purposes of estimating factor validity. Table 6 shows that a two-factor solution was consistent with pre-study PHQ items clustering on one construct and pre-study GAD-7 items clustering on the second construct. This finding is consistent with Spitzer et al. (2006) and provides further confirmation of validity for these two measures generally.

Table 6: Pre-study PHQ/GAD-7 Factor Validity

Question	**Component**	
	GAD-7	**PHQ-9**
PHQ1		0.811
PHQ2		0.787
PHQ3		0.794
PHQ4		0.797
PHQ5		0.596

PHQ6		0.742
PHQ7	0.399	0.524
PHQ8	0.507	0.483
PHQ9		0.667
GAD1	0.911	
GAD2	0.879	
GAD3	0.851	
GAD4	0.699	
GAD5	0.735	
GAD6	0.566	0.378
GAD7	0.817	0.378

A second factor analysis was conducted to explore facility for the post-study PHQ and GAD-7 items. There is a two-factor solution, which is a little less consistent than the pre-study PHQ and GAD-7 items. It would appear that some PHQ items overlapped onto the GAD-7 measure (Table 7).

Table 7: Post-study PHQ and GAD-7 Factor Validity

Question	**Component**	
	GAD-7	**PHQ-9**
PHQ1	0.478	5.98
PHQ2	0.477	0.65

PHQ3	0.578	0.366
PHQ4	0.572	0.451
PHQ5	0.412	0.467
PHQ6		0.547
PHQ7		0.746
PHQ8		0.711
PHQ9		0.74
GAD1	0.825	
GAD2	0.812	
GAD3	0.896	
GAD4	0.739	
GAD5	0.69	0.33
GAD6	0.34	0.548
GAD7	0.627	

A principle components factor analysis using varimax rotation was also applied to the THA and CHA measures, respectively. Luborsky et al. (1996) had presented the results from the entire scale because initial factor loading explained little variation. Tables 8 and 9 are consistent with a single component solution for the THA and CHA measure, respectively. Items on these measures that are negatively worded are reverse scored items and they correlate negatively with the single factor scale as anticipated.

Table 8: Factor validity for THA Measure

Table 9: Factor validity analysis for the CHA Measure

Question	Component 1
CHAQ1	0.714
CHAQ2	0.731
CHAQ3	0.557
CHAQ4	-0.632
CHAQ5	0.706
CHAQ6	0.778
CHAQ7	0.775
CHAQ8	-0.675
CHAQ9	0.818
CHAQ10	0.863
CHAQ11	-0.436
CHAQ12	0.901
CHAQ13	0.825
CHAQ14	0.672
CHAQ15	0.798
CHAQ16	-0.528
CHAQ17	0.732
CHAQ18	0.706

CHAQ19	0.399

Lastly, a principle components factor analysis using varimax rotation was used to estimate validity for the therapist and client attachment questionnaires (See Table 10 and Table 11). A single factor solution was somewhat consistent with the therapist and client attachment questionnaires, respectively. Negatively worded items are reversed scored on these scales negatively correlate for the client attachment questionnaire. Some of negatively worded items on the therapist questionnaire showed no correlations, which will be discussed in the limitations section. It could be that the questionnaire is more applicable to clients than therapists generally when factor validity is concerned.

Table 10: Therapist Attachment Questionnaire

Question No.	**Component 1**
ECR-RS T1	0.723
ECR-RS T2	0.865
ECR-RS T3	0.724
ECR-RS T4	0.608
ECR-RS T5	-0.61
ECR-RS T6	-0.54
ECR-RS T7	
ECR-RS T8	

ECR-RS T9	-0.384

Table 11: Client Attachment Questionnaire

Question No.	**Component 1**
ECR-RS C1	-0.78
ECR-RS C2	-0.814
ECR-RS C3	-0.873
ECR-RS C4	-0.775
ECR-RS C5	0.788
ECR-RS C6	0.786
ECR-RS C7	0.872
ECR-RS C8	0.787
ECR-RS C9	0.726

Appendix 19

Authors Permission to use ECR-RS for the study

Resent-From: <wendy.nicholls@wlv.ac.uk>

From: "R. Chris Fraley" <rcfraley@gmail.com>

Date: 1 April 2014 10:55:15 BST

To: "Nicholls, Wendy" <Wendy.Nicholls@wlv.ac.uk>

Subject: Re: Permission to use scale

Please feel free to use it. Good luck with your work.

~ Chris

R. Chris Fraley

University of Illinois at Urbana-Champaign

Department of Psychology

603 East Daniel Street

Champaign, IL 61820

Internet: http://www.psych.uiuc.edu/~rcfraley/

On Tue, Apr 1, 2014 at 4:47 AM, Wendy Nicholls <wendy.nicholls@wlv.ac.uk> wrote:

Dear Chris,

Can we ask your permission to use the ECR-RS in a doctoral research project on the attachment of therapists and clients please? The questionnaire will be posted to participants. If you require further details, I'm happy to supply them. Many thanks for your time.

all the best,

Wendy

Dr Wendy Nicholls

Senior Lecturer in Psychology

Faculty of Health, Education, & Wellbeing

University of Wolverhampton

Mary Seacole Building

Nursery street

Wolverhampton

WV1 1AD

UK

Tel: 01902 321359

http://www.wlv.ac.uk/default.aspx?page=22982

To book an appointment: http://shawsams.wlv.ac.uk/

Appendix 20

Client Frequencies

Statistics

		Cgender	Cage	Cethnicity	Crelation_stats	Csexualo	Cchildren	Ccouns_b4
N	Valid	38	38	38	38	38	38	38
	Missing	0	0	0	0	0	0	0

Frequency Table

Cgender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	15	39.5	39.5	39.5
	Female	23	60.5	60.5	100.0
	Total	38	100.0	100.0	

Cage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<25	9	23.7	23.7	23.7
	26-35	11	28.9	28.9	52.6
	36-45	9	23.7	23.7	76.3
	46-55	6	15.8	15.8	92.1
	>55	3	7.9	7.9	100.0
	Total	38	100.0	100.0	

Cethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	29	76.3	76.3	76.3
	Asian	7	18.4	18.4	94.7

	Afro-Caribbean	1	2.6	2.6	97.4
	Other	1	2.6	2.6	100.0
	Total	38	100.0	100.0	

Crelation_stats

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	18	47.4	47.4	47.4
	Single	10	26.3	26.3	73.7
	Divorced	5	13.2	13.2	86.8
	Widowed	1	2.6	2.6	89.5
	Cohabiting	4	10.5	10.5	100.0
	Total	38	100.0	100.0	

Csexualo

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Heterosexual	33	86.8	86.8	86.8
	Gay	2	5.3	5.3	92.1
	Bisexual	1	2.6	2.6	94.7
	Prefer not to comment	2	5.3	5.3	100.0
	Total	38	100.0	100.0	

Cchildren

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	22	57.9	57.9	57.9
	No	16	42.1	42.1	100.0
	Total	38	100.0	100.0	

Ccouns_b4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	24	63.2	63.2	63.2
	No	14	36.8	36.8	100.0
	Total	38	100.0	100.0	

Cdisorder

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Anxiety	10	26.3	26.3	26.3
	Depression	6	15.8	15.8	42.1
	Both	22	57.9	57.9	100.0
	Total	38	100.0	100.0	

Correlations

Correlations

		Cgender	Cage	Cethnicity	Crelation_stats	Csexualo	Cchildren
Cgender	Pearson Correlation	1	-.075	-.022	-.276	-.004	-.075
	Sig. (2-tailed)		.655	.897	.093	.982	.656
	N	38	38	38	38	38	38
Cage	Pearson Correlation	-.075	1	-.086	-.242	-.386*	-.687**
	Sig. (2-tailed)	.655		.607	.143	.017	.000
	N	38	38	38	38	38	38
Cethnicity	Pearson Correlation	-.022	-.086	1	.021	.045	.241
	Sig. (2-tailed)	.897	.607		.898	.787	.146
	N	38	38	38	38	38	38
Crelation_stats	Pearson Correlation	-.276	-.242	.021	1	.156	.190
	Sig. (2-tailed)	.093	.143	.898		.348	.254
	N	38	38	38	38	38	38
Csexualo	Pearson Correlation	-.004	-.386*	.045	.156	1	.412*
	Sig. (2-tailed)	.982	.017	.787	.348		.010
	N	38	38	38	38	38	38
Cchildren	Pearson Correlation	-.075	-.687**	.241	.190	.412*	1

	Sig. (2-tailed)	.656	.000	.146	.254	.010	
	N	38	38	38	38	38	38
	Pearson Correlation	-.164	.012	.132	-.016	.096	.122
Ccouns_b4	Sig. (2-tailed)	.324	.945	.430	.926	.568	.465
	N	38	38	38	38	38	38
	Pearson Correlation	.046	.307	.010	-.197	-.292	-.436**
Cdisorder	Sig. (2-tailed)	.784	.060	.953	.235	.076	.006
	N	38	38	38	38	38	38

Correlations

		Ccouns_b4	Cdisorder
	Pearson Correlation	-.164	.046
Cgender	Sig. (2-tailed)	.324	.784
	N	38	38
	Pearson Correlation	.012	.307
Cage	Sig. (2-tailed)	.945	.060
	N	38	38
	Pearson Correlation	.132	.010
Cethnicity	Sig. (2-tailed)	.430	.953
	N	38	38
	Pearson Correlation	-.016	-.197
Crelation_stats	Sig. (2-tailed)	.926	.235
	N	38	38
	Pearson Correlation	.096	-.292*
Csexualo	Sig. (2-tailed)	.568	.076
	N	38	38
	Pearson Correlation	.122	-.436**
Cchildren	Sig. (2-tailed)	.465	.006
	N	38	38
	Pearson Correlation	1	-.280
Ccouns_b4	Sig. (2-tailed)		.089
	N	38	38
	Pearson Correlation	-.280	1
Cdisorder	Sig. (2-tailed)	.089	
	N	38	38

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Frequencies

Statistics

		predepdiag	postdepdiag	preanxdiag	postanxdiag
N	Valid	38	38	38	38
	Missing	0	0	0	0

Frequency Table

predepdiag

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Minimal	2	5.3	5.3	5.3
	Mild	4	10.5	10.5	15.8
	Moderate	8	21.1	21.1	36.8
	Moderately Severe	11	28.9	28.9	65.8
	Severe	13	34.2	34.2	100.0
	Total	38	100.0	100.0	

postdepdiag

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Minimal	7	18.4	18.4	18.4
	Mild	15	39.5	39.5	57.9
	Moderate	11	28.9	28.9	86.8
	Moderately Severe	4	10.5	10.5	97.4
	Severe	1	2.6	2.6	100.0
	Total	38	100.0	100.0	

preanxdiag

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Minimal	3	7.9	7.9	7.9
	Mild	4	10.5	10.5	18.4

	Moderate	14	36.8	36.8	55.3
	Moderately Severe	10	26.3	26.3	81.6
	Severe	7	18.4	18.4	100.0
	Total	38	100.0	100.0	

Therapist Frequencies

Statistics

		Tprofession	Twork_place	Tgender	Tage	Tethnicity	Tstudent	Tyip
N	Valid	38	38	38	38	38	38	38
	Missing	0	0	0	0	0	0	0

Frequency Table

Tprofession

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinical Psychologist	13	34.2	34.2	34.2
	Counselling Psychologist	19	50.0	50.0	84.2
	Chartered Psychologist	6	15.8	15.8	100.0
	Total	38	100.0	100.0	

Twork_place

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Psychology Department	9	23.7	23.7	23.7
	Multi-disciplinary Team	3	7.9	7.9	31.6
	Health Centre	1	2.6	2.6	34.2
	In-patients Department	1	2.6	2.6	36.8
	Private	24	63.2	63.2	100.0
	Total	38	100.0	100.0	

Tgender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	14	36.8	36.8	36.8
	Female	24	63.2	63.2	100.0
	Total	38	100.0	100.0	

Tage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<25	3	7.9	7.9	7.9
	26-35	7	18.4	18.4	26.3
	36-45	13	34.2	34.2	60.5
	46-55	10	26.3	26.3	86.8
	>55	5	13.2	13.2	100.0
	Total	38	100.0	100.0	

Tethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	30	78.9	78.9	78.9
	Asian	7	18.4	18.4	97.4
	Afro-Caribbean	1	2.6	2.6	100.0
	Total	38	100.0	100.0	

Tstudent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	28.9	28.9	28.9
	No	27	71.1	71.1	100.0

	Total	38	100.0	100.0	

Tyip

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<2 years	5	13.2	13.2	13.2
	2-5 years	7	18.4	18.4	31.6
	6-10 years	15	39.5	39.5	71.1
	11+ years	11	28.9	28.9	100.0
	Total	38	100.0	100.0	

Tapproach

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	EMDR	10	26.3	26.3	26.3
	CBT	10	26.3	26.3	52.6
	Person Centred	8	21.1	21.1	73.7
	Intergrative	10	26.3	26.3	100.0
	Total	38	100.0	100.0	

Attachment Style Frequencies

Statistics

		Cecr	Tecr
N	Valid	38	38
	Missing	0	0

Frequency Table

Cecr

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secure	19	50.0	50.0	50.0
	Preoccupied	2	5.3	5.3	55.3
	Dismissive	2	5.3	5.3	60.5
	Fearful	15	39.5	39.5	100.0
	Total	38	100.0	100.0	

Tecr

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Secure	23	60.5	60.5	60.5
	Preoccupied	7	18.4	18.4	78.9
	Dismissive	3	7.9	7.9	86.8
	Fearful	5	13.2	13.2	100.0
	Total	38	100.0	100.0	

Frequencies

Statistics

comb

N	Valid	38
	Missing	0

comb

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	9	23.7	23.7	23.7
	2.00	5	13.2	13.2	36.8
	3.00	1	2.6	2.6	39.5
	4.00	4	10.5	10.5	50.0
	5.00	1	2.6	2.6	52.6
	6.00	1	2.6	2.6	55.3

	9.00	2	5.3	5.3	60.5
	13.00	11	28.9	28.9	89.5
	14.00	1	2.6	2.6	92.1
	15.00	2	5.3	5.3	97.4
	16.00	1	2.6	2.6	100.0
	Total	38	100.0	100.0	

Descriptives

Descriptive Statistics

comb		N	Minimum	Maximum	Mean	Std. Deviatio
	CAllianceMean	9	4.26	6.00	5.3977	.69
	TAllianceMean	9	5.16	6.00	5.5556	.26
	DepressionPre	9	4.00	20.00	14.7778	6.07
1.00	DepressionPost	9	2.00	17.00	5.6667	5.07
	AnxietyPre	9	10.00	20.00	15.7778	3.52
	AnxietyPost	9	2.00	9.00	4.5556	2.78
	Valid N (listwise)	9				
	CAllianceMean	5	4.16	5.68	5.0737	.68
	TAllianceMean	5	4.47	5.89	4.9474	.58
	DepressionPre	5	4.00	15.00	9.2000	4.08
2.00	DepressionPost	5	3.00	8.00	5.2000	1.78
	AnxietyPre	5	3.00	11.00	7.6000	3.13
	AnxietyPost	5	2.00	7.00	4.2000	2.16
	Valid N (listwise)	5				
	CAllianceMean	1	5.74	5.74	5.7368	
	TAllianceMean	1	6.00	6.00	6.0000	
	DepressionPre	1	10.00	10.00	10.0000	
3.00	DepressionPost	1	6.00	6.00	6.0000	
	AnxietyPre	1	10.00	10.00	10.0000	
	AnxietyPost	1	7.00	7.00	7.0000	
	Valid N (listwise)	1				
	CAllianceMean	4	3.16	4.79	4.0000	.66
4.00	TAllianceMean	4	3.58	4.63	4.2237	.45
	DepressionPre	4	9.00	27.00	18.5000	8.42

	DepressionPost	4	6.00	21.00	14.2500	6.39(
	AnxietyPre	4	7.00	21.00	15.7500	6.701
	AnxietyPost	4	6.00	17.00	11.7500	4.787
	Valid N (listwise)	4				
5.00	CAllianceMean	1	6.00	6.00	6.0000	
	TAllianceMean	1	5.26	5.26	5.2632	
	DepressionPre	1	18.00	18.00	18.0000	
	DepressionPost	1	9.00	9.00	9.0000	
	AnxietyPre	1	15.00	15.00	15.0000	
	AnxietyPost	1	5.00	5.00	5.0000	

Descriptive Statistics

comb		N	Minimum	Maximum	Mean	Std. Deviation
5.00	Valid N (listwise)	1				
	CAllianceMean	1	4.84	4.84	4.8421	.
	TAllianceMean	1	4.47	4.47	4.4737	.
	DepressionPre	1	17.00	17.00	17.0000	.
6.00	DepressionPost	1	7.00	7.00	7.0000	.
	AnxietyPre	1	18.00	18.00	18.0000	.
	AnxietyPost	1	3.00	3.00	3.0000	.
	Valid N (listwise)	1				
	CAllianceMean	2	4.32	6.00	5.1579	1.19092
	TAllianceMean	2	4.00	6.00	5.0000	1.41421
	DepressionPre	2	19.00	21.00	20.0000	1.41421
9.00	DepressionPost	2	11.00	12.00	11.5000	.70711
	AnxietyPre	2	4.00	11.00	7.5000	4.94975
	AnxietyPost	2	.00	6.00	3.0000	4.24264
	Valid N (listwise)	2				
	CAllianceMean	11	3.84	6.00	5.3541	.71783
	TAllianceMean	11	4.26	6.00	5.4833	.59955
	DepressionPre	11	8.00	26.00	18.2727	5.93449
13.00	DepressionPost	11	5.00	17.00	10.4545	3.64318
	AnxietyPre	11	4.00	21.00	13.1818	4.68654
	AnxietyPost	11	3.00	12.00	7.6364	2.54058
	Valid N (listwise)	11				
	CAllianceMean	1	4.63	4.63	4.6316	.
	TAllianceMean	1	3.89	3.89	3.8947	.
14.00	DepressionPre	1	25.00	25.00	25.0000	.
	DepressionPost	1	11.00	11.00	11.0000	.
	AnxietyPre	1	18.00	18.00	18.0000	.

	AnxietyPost	1	8.00	8.00	8.0000	.
	Valid N (listwise)	1				
	CAllianceMean	2	4.00	4.79	4.3947	.55824
	TAllianceMean	2	4.21	4.32	4.2632	.07443
15.00	DepressionPre	2	14.00	27.00	20.5000	9.19239
	DepressionPost	2	13.00	17.00	15.0000	2.82843
	AnxietyPre	2	15.00	21.00	18.0000	4.24264

Descriptive Statistics

comb		N	Minimum	Maximum	Mean	Std. Deviation
15.00	AnxietyPost	2	11.00	14.00	12.5000	2.12132
	Valid N (listwise)	2				
	CAllianceMean	1	4.68	4.68	4.6842	.
	TAllianceMean	1	4.26	4.26	4.2632	.
	DepressionPre	1	16.00	16.00	16.0000	.
16.00	DepressionPost	1	6.00	6.00	6.0000	.
	AnxietyPre	1	18.00	18.00	18.0000	.
	AnxietyPost	1	7.00	7.00	7.0000	.
	Valid N (listwise)	1				

Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
	Valid	38	100.0
Cases	Excluded[a]	0	.0
	Total	38	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items[a]	N of Items
.304	-.125	8

a. The value is negative due to a negative average covariance among items. This violates reliability model assumptions. You may want to check item codings.

Item Statistics

	Mean	Std. Deviation	N
CGlobalAnx	3.3114	1.17155	38
CGlobalAvoid	3.5110	1.99344	38
TGlobalAnx	2.9649	.99918	38
TGlobalAvoid	2.3114	1.33821	38
TAllianceMean	5.1150	.72763	38
CAllianceMean	5.1011	.78823	38
DepressionChange	7.3684	4.52274	38
AnxietyChange	6.9474	4.82083	38

Inter-Item Correlation Matrix

	CGlobalAnx	CGlobalAvoid	TGlobalAnx	TGlobalAvoid	TAllianceMean	CAllianceMean
CGlobalAnx	1.000	.819	-.082	-.116	-.126	.022
CGlobalAvoid	.819	1.000	-.181	.019	-.016	.104
TGlobalAnx	-.082	-.181	1.000	.420	-.666	-.520
TGlobalAvoid	-.116	.019	.420	1.000	-.455	-.506
TAllianceMean	-.126	-.016	-.666	-.455	1.000	.757
CAllianceMean	.022	.104	-.520	-.506	.757	1.000
DepressionChange	.121	.070	-.396	-.405	.200	.372
AnxietyChange	-.111	-.192	-.282	-.321	.104	.313

Inter-Item Correlation Matrix

	DepressionChange	AnxietyChange
CGlobalAnx	.121	-.111
CGlobalAvoid	.070	-.192
TGlobalAnx	-.396	-.282
TGlobalAvoid	-.405	-.321
TAllianceMean	.200	.104
CAllianceMean	.372	.313
DepressionChange	1.000	.662
AnxietyChange	.662	1.000

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	4.579	2.311	7.368	5.057	3.188	3.492	8

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
36.6305	72.158	8.49457	8

Factor Analysis

Communalities

	Initial	Extraction
Little interest or pleasure in doing things?	1.000	.712
Feeling down, depressed, or hopeless?	1.000	.665
Trouble falling or staying asleep, or sleeping too much?	1.000	.625
Feeling tired or having little energy?	1.000	.792
Poor appetite or overeating?	1.000	.544

Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	1.000	.571
Trouble concentrating on things, such as reading the newspaper or watching television?	1.000	.645
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	1.000	.796
Thoughts that you would be better off dead, or of hurting yourself in some way?	1.000	.711

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	4.741	52.673	52.673	4.741	52.673	52.673	3.452
2	1.319	14.661	67.334	1.319	14.661	67.334	2.608
3	.869	9.655	76.989				
4	.581	6.459	83.447				
5	.483	5.369	88.816				
6	.430	4.776	93.592				
7	.306	3.405	96.997				
8	.192	2.130	99.127				
9	.079	.873	100.000				

Total Variance Explained

Component	Rotation Sums of Squared Loadings

	% of Variance	Cumulative %
1	38.358	38.358
2	28.976	67.334
3		
4		
5		
6		
7		
8		
9		

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2
Little interest or pleasure in doing things?	.777	-.328
Feeling down, depressed, or hopeless?	.815	
Trouble falling or staying asleep, or sleeping too much?	.787	
Feeling tired or having little energy?	.814	-.360
Poor appetite or overeating?	.650	-.349
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	.674	-.342
Trouble concentrating on things, such as reading the newspaper or watching television?	.632	.496

Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	.648	.614
Thoughts that you would be better off dead, or of hurting yourself in some way?	.704	.463

Extraction Method: Principal Component Analysis.[a]
a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
Little interest or pleasure in doing things?	.815	
Feeling down, depressed, or hopeless?	.623	.526
Trouble falling or staying asleep, or sleeping too much?	.667	.424
Feeling tired or having little energy?	.863	
Poor appetite or overeating?	.727	
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	.742	
Trouble concentrating on things, such as reading the newspaper or watching television?		.779

Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	.882
Thoughts that you would be better off dead, or of hurting yourself in some way?	.798

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.[a]
a. Rotation converged in 3 iterations.

Component Transformation Matrix

Component	1	2
1	.790	.614
2	-.614	.790

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Factor Analysis

Communalities

	Initial	Extraction
Little interest or pleasure in doing things?	1.000	.664

Feeling down, depressed, or hopeless?	1.000	.689
Trouble falling or staying asleep, or sleeping too much?	1.000	.636
Feeling tired or having little energy?	1.000	.679
Poor appetite or overeating?	1.000	.419
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	1.000	.561
Trouble concentrating on things, such as reading the newspaper or watching television?	1.000	.434
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	1.000	.491
Thoughts that you would be better off dead, or of hurting yourself in some way?	1.000	.469
Feeling nervous, anxious or on edge	1.000	.849
Not being able to stop or control worrying	1.000	.806
Worrying too much about different things	1.000	.747

Communalities

	Initial	Extraction
Trouble relaxing	1.000	.532
Being so restless that it is hard to sit still	1.000	.542
Becoming easily annoyed or irritable	1.000	.463
Feeling afraid as if something awful might happen	1.000	.758

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	6.792	42.447	42.447	6.792	42.447	42.447	4.981
2	2.946	18.412	60.859	2.946	18.412	60.859	4.756
3	1.485	9.284	70.143				
4	1.115	6.966	77.109				
5	.776	4.848	81.957				
6	.692	4.328	86.285				
7	.568	3.548	89.833				
8	.475	2.968	92.801				
9	.323	2.019	94.821				
10	.224	1.397	96.218				
11	.201	1.257	97.475				
12	.128	.799	98.274				
13	.126	.785	99.060				
14	.074	.465	99.525				
15	.047	.295	99.819				
16	.029	.181	100.000				

Total Variance Explained

Component	Rotation Sums of Squared Loadings	
	% of Variance	Cumulative %
1	31.134	31.134
2	29.725	60.859
3		
4		
5		
6		
7		
8		
9		

10
11
12
13
14
15
16

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2
Little interest or pleasure in doing things?	.612	.538
Feeling down, depressed, or hopeless?	.731	.392
Trouble falling or staying asleep, or sleeping too much?	.596	.530
Feeling tired or having little energy?	.699	.437
Poor appetite or overeating?	.593	
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	.433	.612
Trouble concentrating on things, such as reading the newspaper or watching television?	.650	
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	.700	

Thoughts that you would be better off dead, or of hurting yourself in some way?	.571	.378
Feeling nervous, anxious or on edge	.566	-.727
Not being able to stop or control worrying	.765	-.469

Component Matrix[a]

	Component	
	1	2
Worrying too much about different things	.721	-.476
Trouble relaxing	.651	-.328
Being so restless that it is hard to sit still	.567	-.470
Becoming easily annoyed or irritable	.671	
Feeling afraid as if something awful might happen	.800	-.343

Extraction Method: Principal Component Analysis.[a]
a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
Little interest or pleasure in doing things?		.811
Feeling down, depressed, or hopeless?		.787
Trouble falling or staying asleep, or sleeping too much?		.794
Feeling tired or having little energy?		.797
Poor appetite or overeating?		.596

Feeling bad about yourself - or that you are a failure or have let yourself or your family down?		.742
Trouble concentrating on things, such as reading the newspaper or watching television?	.399	.524
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	.507	.483
Thoughts that you would be better off dead, or of hurting yourself in some way?		.667
Feeling nervous, anxious or on edge	.911	
Not being able to stop or control worrying	.879	

Rotated Component Matrix[a]

	Component	
	1	2
Worrying too much about different things	.851	
Trouble relaxing	.699	
Being so restless that it is hard to sit still	.735	
Becoming easily annoyed or irritable	.566	.378
Feeling afraid as if something awful might happen	.817	

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.[a]
a. Rotation converged in 3 iterations.

Component Transformation Matrix

Component	1	2
1	.728	.686
2	-.686	.728

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Factor Analysis

Communalities

	Initial	Extraction
Little interest or pleasure in doing things?	1.000	.586
Feeling down, depressed, or hopeless?	1.000	.651
Trouble falling or staying asleep, or sleeping too much?	1.000	.468
Feeling tired or having little energy?	1.000	.530
Poor appetite or overeating?	1.000	.388
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	1.000	.357
Trouble concentrating on things, such as reading the newspaper or watching television?	1.000	.631

Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	1.000	.583
Thoughts that you would be better off dead, or of hurting yourself in some way?	1.000	.588
Feeling nervous, anxious or on edge	1.000	.701
Not being able to stop or control worrying	1.000	.720
Worrying too much about different things	1.000	.884

Communalities

	Initial	Extraction
Trouble relaxing	1.000	.584
Being so restless that it is hard to sit still	1.000	.586
Becoming easily annoyed or irritable	1.000	.416
Feeling afraid as if something awful might happen	1.000	.404

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	7.458	46.614	46.614	7.458	46.614	46.614	5.211
2	1.619	10.121	56.736	1.619	10.121	56.736	3.866
3	1.359	8.492	65.228				
4	1.176	7.350	72.578				

5	.977	6.105	78.683
6	.659	4.116	82.799
7	.647	4.046	86.845
8	.538	3.360	90.205
9	.346	2.162	92.367
10	.329	2.057	94.424
11	.279	1.746	96.170
12	.222	1.386	97.556
13	.144	.901	98.457
14	.133	.830	99.287
15	.076	.474	99.761
16	.038	.239	100.000

Total Variance Explained

Component	Rotation Sums of Squared Loadings	
	% of Variance	Cumulative %
1	32.571	32.57
2	24.165	56.73
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2

Little interest or pleasure in doing things?	.746	
Feeling down, depressed, or hopeless?	.778	
Trouble falling or staying asleep, or sleeping too much?	.680	
Feeling tired or having little energy?	.728	
Poor appetite or overeating?	.613	
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	.528	
Trouble concentrating on things, such as reading the newspaper or watching television?	.677	.415
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	.659	.385
Thoughts that you would be better off dead, or of hurting yourself in some way?	.303	.705
Feeling nervous, anxious or on edge	.734	-.402
Not being able to stop or control worrying	.790	-.309

Component Matrix[a]

	Component	
	1	2
Worrying too much about different things	.879	-.332
Trouble relaxing	.700	-.306
Being so restless that it is hard to sit still	.746	

Becoming easily annoyed or irritable	.607	
Feeling afraid as if something awful might happen	.558	-.306

Extraction Method: Principal Component Analysis.[a]
a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
Little interest or pleasure in doing things?	.478	.598
Feeling down, depressed, or hopeless?	.477	.650
Trouble falling or staying asleep, or sleeping too much?	.578	.366
Feeling tired or having little energy?	.572	.451
Poor appetite or overeating?	.412	.467
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?		.547
Trouble concentrating on things, such as reading the newspaper or watching television?		.746
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?		.711
Thoughts that you would be better off dead, or of hurting yourself in some way?		.740

Feeling nervous, anxious or on edge	.825
Not being able to stop or control worrying	.812

Rotated Component Matrix[a]

	Component	
	1	2
Worrying too much about different things	.896	
Trouble relaxing	.739	
Being so restless that it is hard to sit still	.690	.330
Becoming easily annoyed or irritable	.340	.548
Feeling afraid as if something awful might happen	.627	

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.[a]
a. Rotation converged in 3 iterations.

Component Transformation Matrix

Component	1	2
1	.784	.620
2	-.620	.784

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Factor Analysis

Communalities

	Initial	Extraction
The patient feels I want him/her to achieve the goals.	1.000	.731
At times the patient distrusts my judgment.	1.000	.585
The patient feels he/she is working together with me in a joint effort.	1.000	.740
I believe we have similar ideas about the nature of his/her problems.	1.000	.564
The patient generally respects my views about him/her.	1.000	.746
The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	1.000	.796
The patient likes me as a person.	1.000	.438
In most sessions, we find a way to work on his/her problems together.	1.000	.501
The patient believes I relate to him/her in ways that slow up the progress of the therapy.	1.000	.499
The patient believes a good relationship has formed between us.	1.000	.711
The patient believes I am experienced in helping people.	1.000	.706

Communalities

	Initial	Extraction
I want very much for the patient to work out his/her problems.	1.000	.707
The patient and I have meaningful exchanges.	1.000	.685

The patient and I sometimes have unprofitable exchanges.	1.000	.506
From time to time, we both talk about the same important events in his/her past.	1.000	.799
The patient believes I like him/her as a person.	1.000	.697
At times the patient sees me as distant.	1.000	.737

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	8.880	52.234	52.234	8.880	52.234	52.234	6.437
2	2.265	13.326	65.560	2.265	13.326	65.560	4.708
3	.996	5.861	71.421				
4	.906	5.329	76.750				
5	.758	4.462	81.211				
6	.670	3.944	85.155				
7	.500	2.940	88.096				
8	.450	2.649	90.745				
9	.334	1.966	92.711				
10	.307	1.803	94.514				
11	.263	1.547	96.061				
12	.222	1.307	97.368				
13	.147	.865	98.233				
14	.122	.718	98.951				
15	.075	.442	99.393				
16	.069	.408	99.801				
17	.034	.199	100.000				

Total Variance Explained

Component	Rotation Sums of Squared Loadings

	% of Variance	Cumulative %
1	37.867	37.867
2	27.693	65.560
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2
The patient feels I want him/her to achieve the goals.	.599	.610
At times the patient distrusts my judgment.	-.601	.473
The patient feels he/she is working together with me in a joint effort.	.794	-.330
I believe we have similar ideas about the nature of his/her problems.	.751	
The patient generally respects my views about him/her.	.845	

The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	-.637	.625
The patient likes me as a person.	.654	
In most sessions, we find a way to work on his/her problems together.	.706	
The patient believes I relate to him/her in ways that slow up the progress of the therapy.	-.667	
The patient believes a good relationship has formed between us.	.830	
The patient believes I am experienced in helping people.	.783	-.305

Component Matrix[a]

	Component	
	1	2
I want very much for the patient to work out his/her problems.	.540	.645
The patient and I have meaningful exchanges.	.827	
The patient and I sometimes have unprofitable exchanges.	-.693	
From time to time, we both talk about the same important events in his/her past.	.691	.567
The patient believes I like him/her as a person.	.832	
At times the patient sees me as distant.	-.740	-.436

Extraction Method: Principal Component Analysis.[a]
a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
The patient feels I want him/her to achieve the goals.		.848
At times the patient distrusts my judgment.	-.765	
The patient feels he/she is working together with me in a joint effort.	.831	
I believe we have similar ideas about the nature of his/her problems.	.605	.445
The patient generally respects my views about him/her.	.778	.374
The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	-.886	
The patient likes me as a person.	.581	.317
In most sessions, we find a way to work on his/her problems together.	.584	.399
The patient believes I relate to him/her in ways that slow up the progress of the therapy.	-.390	-.589
The patient believes a good relationship has formed between us.	.750	.386
The patient believes I am experienced in helping people.	.807	

Rotated Component Matrix[a]

	Component	
	1	2

I want very much for the patient to work out his/her problems.		.840
The patient and I have meaningful exchanges.	.634	.532
The patient and I sometimes have unprofitable exchanges.	-.649	
From time to time, we both talk about the same important events in his/her past.		.870
The patient believes I like him/her as a person.	.617	.563
At times the patient sees me as distant.	-.323	-.795

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.[a]
a. Rotation converged in 3 iterations.

Component Transformation Matrix

Component	1	2
1	.794	.608
2	-.608	.794

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Factor Analysis

Communalities

	Initial	Extraction

The patient feels I want him/her to achieve the goals.	1.000	.359
At times the patient distrusts my judgment.	1.000	.361
The patient feels he/she is working together with me in a joint effort.	1.000	.631
I believe we have similar ideas about the nature of his/her problems.	1.000	.564
The patient generally respects my views about him/her.	1.000	.715
The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	1.000	.406
The patient likes me as a person.	1.000	.428
In most sessions, we find a way to work on his/her problems together.	1.000	.499
The patient believes I relate to him/her in ways that slow up the progress of the therapy.	1.000	.446
The patient believes a good relationship has formed between us.	1.000	.689
The patient believes I am experienced in helping people.	1.000	.613

Communalities

	Initial	Extraction
I want very much for the patient to work out his/her problems.	1.000	.292
The patient and I have meaningful exchanges.	1.000	.683
The patient and I sometimes have unprofitable exchanges.	1.000	.480

From time to time, we both talk about the same important events in his/her past.	1.000	.478
The patient believes I like him/her as a person.	1.000	.692
At times the patient sees me as distant.	1.000	.547

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.880	52.234	52.234	8.880	52.234	52.234
2	2.265	13.326	65.560			
3	.996	5.861	71.421			
4	.906	5.329	76.750			
5	.758	4.462	81.211			
6	.670	3.944	85.155			
7	.500	2.940	88.096			
8	.450	2.649	90.745			
9	.334	1.966	92.711			
10	.307	1.803	94.514			
11	.263	1.547	96.061			
12	.222	1.307	97.368			
13	.147	.865	98.233			
14	.122	.718	98.951			
15	.075	.442	99.393			
16	.069	.408	99.801			
17	.034	.199	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component
	1

The patient feels I want him/her to achieve the goals.	.599
At times the patient distrusts my judgment.	-.601
The patient feels he/she is working together with me in a joint effort.	.794
I believe we have similar ideas about the nature of his/her problems.	.751
The patient generally respects my views about him/her.	.845
The patient believes the procedures used in his/her therapy are not well suited to his/her needs.	-.637
The patient likes me as a person.	.654
In most sessions, we find a way to work on his/her problems together.	.706
The patient believes I relate to him/her in ways that slow up the progress of the therapy.	-.667
The patient believes a good relationship has formed between us.	.830
The patient believes I am experienced in helping people.	.783

Component Matrix[a]

	Component 1
I want very much for the patient to work out his/her problems.	.540
The patient and I have meaningful exchanges.	.827
The patient and I sometimes have unprofitable exchanges.	-.693

From time to time, we both talk about the same important events in his/her past.	.691
The patient believes I like him/her as a person.	.832
At times the patient sees me as distant.	-.740

Extraction Method: Principal Component Analysis.[a]
a. 1 components extracted.

Factor Analysis

Communalities

	Initial	Extraction
I feel I can depend upon the therapist.	1.000	.510
I feel the therapist understands me.	1.000	.535
I feel the therapist wants me to achieve my goals.	1.000	.311
At times I distrust the therapist's judgment.	1.000	.400
I feel I am working together with the therapist in a joint effort.	1.000	.498
I believe we have similar ideas about the nature of my problems.	1.000	.606
I generally respect the therapist's views about me.	1.000	.601
The procedures used in my therapy are not well suited to my needs.	1.000	.456
I like the therapist as a person.	1.000	.670

In most sessions, the therapist and I find a way to work on my problems together.	1.000	.746
The therapist relates to me in ways that slow up the progress of the therapy.	1.000	.191
A good relationship has formed with my therapist.	1.000	.812
The therapist appears to be experienced in helping people	1.000	.681

Communalities

	Initial	Extraction
I want very much to work out my problems.	1.000	.451
The therapist and I have meaningful exchanges.	1.000	.636
The therapist and I sometimes have unprofitable exchanges.	1.000	.278
From time to time, we both talk about the same important events in my past.	1.000	.536
I believe the therapist likes me as a person.	1.000	.499
At times the therapist seems distant.	1.000	.159

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	9.573	50.386	50.386	9.573	50.386	50.386
2	3.637	19.139	69.526			
3	1.240	6.527	76.052			
4	.922	4.851	80.904			
5	.863	4.540	85.443			
6	.695	3.656	89.099			

7	.473	2.492	91.591
8	.396	2.085	93.676
9	.271	1.428	95.104
10	.240	1.265	96.369
11	.231	1.213	97.582
12	.144	.756	98.338
13	.097	.510	98.849
14	.074	.388	99.236
15	.059	.311	99.547
16	.033	.174	99.721
17	.029	.154	99.875
18	.017	.088	99.963
19	.007	.037	100.000

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component 1
I feel I can depend upon the therapist.	.714
I feel the therapist understands me.	.731
I feel the therapist wants me to achieve my goals.	.557
At times I distrust the therapist's judgment.	-.632
I feel I am working together with the therapist in a joint effort.	.706
I believe we have similar ideas about the nature of my problems.	.778
I generally respect the therapist's views about me.	.775
The procedures used in my therapy are not well suited to my needs.	-.675

I like the therapist as a person.	.818
In most sessions, the therapist and I find a way to work on my problems together.	.863
The therapist relates to me in ways that slow up the progress of the therapy.	-.436
A good relationship has formed with my therapist.	.901

Component Matrix[a]

	Component 1
The therapist appears to be experienced in helping people	.825
I want very much to work out my problems.	.672
The therapist and I have meaningful exchanges.	.798
The therapist and I sometimes have unprofitable exchanges.	-.528
From time to time, we both talk about the same important events in my past.	.732
I believe the therapist likes me as a person.	.706
At times the therapist seems distant.	-.399

Extraction Method: Principal Component Analysis.[a]
a. 1 components extracted.

Factor Analysis

Communalities

	Initial	Extraction
It helps to turn to this person in times of need	1.000	.754
I usually discuss my problems and concerns with this person	1.000	.824
I talk things over with this person	1.000	.846
I find it easy to depend on this person	1.000	.788
I don't feel comfortable opening up to this person	1.000	.687
I prefer not to show this person how I feel deep down.	1.000	.627
I often worry that this person doesn't really care for me	1.000	.395
I'm afraid that this person may abandon me	1.000	.923
I worry that this person won't care about me as much as I care about him or her	1.000	.890

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	3.150	35.005	35.005	3.150	35.005	35.005	2.624
2	2.500	27.779	62.783	2.500	27.779	62.783	2.245
3	1.083	12.038	74.821	1.083	12.038	74.821	1.866
4	.789	8.768	83.590				
5	.541	6.009	89.599				
6	.419	4.658	94.257				
7	.271	3.011	97.268				
8	.166	1.842	99.110				
9	.080	.890	100.000				

Total Variance Explained

Component	Rotation Sums of Squared Loadings	
	% of Variance	Cumulative %
1	29.150	29.15
2	24.940	54.09
3	20.732	74.82
4		
5		
6		
7		
8		
9		

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component		
	1	2	3
It helps to turn to this person in times of need	.723	.480	
I usually discuss my problems and concerns with this person	.865		
I talk things over with this person	.724		.525
I find it easy to depend on this person	.608	-.379	.524
I don't feel comfortable opening up to this person	-.610	-.444	.342
I prefer not to show this person how I feel deep down.	-.540	-.442	.374
I often worry that this person doesn't really care for me		.549	
I'm afraid that this person may abandon me		.827	.389
I worry that this person won't care about me as much as I care about him or her	-.384	.791	.342

Extraction Method: Principal Component Analysis.[a]
a. 3 components extracted.

Rotated Component Matrix[a]

	Component		
	1	2	3
It helps to turn to this person in times of need	.802		
I usually discuss my problems and concerns with this person	.789		.446
I talk things over with this person			.882
I find it easy to depend on this person			.849
I don't feel comfortable opening up to this person	-.829		
I prefer not to show this person how I feel deep down.	-.788		
I often worry that this person doesn't really care for me		.585	
I'm afraid that this person may abandon me		.957	
I worry that this person won't care about me as much as I care about him or her		.934	

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.[a]
a. Rotation converged in 5 iterations.

Component Transformation Matrix

Component	1	2	3
1	.744	-.320	.587
2	.529	.819	-.224
3	-.409	.477	.778

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Factor Analysis

Communalities

	Initial	Extraction
It helps to turn to this person in times of need	1.000	.790
I usually discuss my problems and concerns with this person	1.000	.912
I talk things over with this person	1.000	.938
I find it easy to depend on this person	1.000	.661
I don't feel comfortable opening up to this person	1.000	.623
I prefer not to show this person how I feel deep down.	1.000	.651
I often worry that this person doesn't really care for me	1.000	.916
I'm afraid that this person may abandon me	1.000	.855
I worry that this person won't care about me as much as I care about him or her	1.000	.782

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total

1	5.781	64.231	64.231	5.781	64.231	64.231	3.668
2	1.347	14.968	79.198	1.347	14.968	79.198	3.460
3	.937	10.415	89.613				
4	.404	4.494	94.107				
5	.213	2.366	96.473				
6	.150	1.666	98.140				
7	.086	.953	99.093				
8	.054	.603	99.696				
9	.027	.304	100.000				

Total Variance Explained

Component	Rotation Sums of Squared Loadings	
	% of Variance	Cumulative %
1	40.759	40.759
2	38.439	79.198
3		
4		
5		
6		
7		
8		
9		

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2
It helps to turn to this person in times of need	-.780	.427
I usually discuss my problems and concerns with this person	-.814	.499
I talk things over with this person	-.873	.419
I find it easy to depend on this person	-.775	
I don't feel comfortable opening up to this person	.788	

I prefer not to show this person how I feel deep down.	.786	
I often worry that this person doesn't really care for me	.872	.393
I'm afraid that this person may abandon me	.787	.485
I worry that this person won't care about me as much as I care about him or her	.726	.505

Extraction Method: Principal Component Analysis.[a]
a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
It helps to turn to this person in times of need	.859	
I usually discuss my problems and concerns with this person	.933	
I talk things over with this person	.921	
I find it easy to depend on this person	.391	-.712
I don't feel comfortable opening up to this person	-.600	.512
I prefer not to show this person how I feel deep down.	-.694	.412
I often worry that this person doesn't really care for me	-.360	.887
I'm afraid that this person may abandon me		.894
I worry that this person won't care about me as much as I care about him or her		.867

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.[a]

a. Rotation converged in 3 iterations.

Component Transformation Matrix

Component	1	2
1	-.724	.690
2	.690	.724

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

Factor Analysis

Communalities

	Initial	Extraction
It helps to turn to this person in times of need	1.000	.608
I usually discuss my problems and concerns with this person	1.000	.662
I talk things over with this person	1.000	.762
I find it easy to depend on this person	1.000	.601
I don't feel comfortable opening up to this person	1.000	.621
I prefer not to show this person how I feel deep down.	1.000	.618
I often worry that this person doesn't really care for me	1.000	.761

I'm afraid that this person may abandon me	1.000	.620
I worry that this person won't care about me as much as I care about him or her	1.000	.528

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.781	64.231	64.231	5.781	64.231	64.231
2	1.347	14.968	79.198			
3	.937	10.415	89.613			
4	.404	4.494	94.107			
5	.213	2.366	96.473			
6	.150	1.666	98.140			
7	.086	.953	99.093			
8	.054	.603	99.696			
9	.027	.304	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component 1
It helps to turn to this person in times of need	-.780
I usually discuss my problems and concerns with this person	-.814
I talk things over with this person	-.873
I find it easy to depend on this person	-.775
I don't feel comfortable opening up to this person	.788

I prefer not to show this person how I feel deep down.	.786
I often worry that this person doesn't really care for me	.872
I'm afraid that this person may abandon me	.787
I worry that this person won't care about me as much as I care about him or her	.726

Extraction Method: Principal Component Analysis.[a]
a. 1 components extracted.

Factor Analysis

Communalities

	Initial	Extraction
It helps to turn to this person in times of need	1.000	.523
I usually discuss my problems and concerns with this person	1.000	.748
I talk things over with this person	1.000	.524
I find it easy to depend on this person	1.000	.370
I don't feel comfortable opening up to this person	1.000	.372
I prefer not to show this person how I feel deep down.	1.000	.291
I often worry that this person doesn't really care for me	1.000	.086
I'm afraid that this person may abandon me	1.000	.087

I worry that this person won't care about me as much as I care about him or her	1.000	.148

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.150	35.005	35.005	3.150	35.005	35.005
2	2.500	27.779	62.783			
3	1.083	12.038	74.821			
4	.789	8.768	83.590			
5	.541	6.009	89.599			
6	.419	4.658	94.257			
7	.271	3.011	97.268			
8	.166	1.842	99.110			
9	.080	.890	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component 1
It helps to turn to this person in times of need	.723
I usually discuss my problems and concerns with this person	.865
I talk things over with this person	.724
I find it easy to depend on this person	.608
I don't feel comfortable opening up to this person	-.610
I prefer not to show this person how I feel deep down.	-.540

I often worry that this person doesn't really care for me	
I'm afraid that this person may abandon me	
I worry that this person won't care about me as much as I care about him or her	-.384

Extraction Method: Principal Component Analysis.[a]
a. 1 components extracted.

Correlation Matrix

Correlations

		AnxietyChange	DepressionChange	ClientAllianceRaw	TherapistAllianceRaw
AnxietyChange	Pearson Correlation	1	.662**	.313	.104
	Sig. (2-tailed)		.000	.055	.533
	N	38	38	38	38
DepressionChange	Pearson Correlation	.662**	1	.372*	.200
	Sig. (2-tailed)	.000		.022	.229
	N	38	38	38	38
ClientAllianceRaw	Pearson Correlation	.313	.372*	1	.757**
	Sig. (2-tailed)	.055	.022		.000
	N	38	38	38	38
TherapistAllianceRaw	Pearson Correlation	.104	.200	.757**	1
	Sig. (2-tailed)	.533	.229	.000	
	N	38	38	38	38
TGlobalAnx	Pearson Correlation	-.282	-.396*	-.520**	-.666**
	Sig. (2-tailed)	.086	.014	.001	.000
	N	38	38	38	38
TGlobalAvoid	Pearson Correlation	-.321*	-.405*	-.506**	-.455**
	Sig. (2-tailed)	.049	.012	.001	.004
	N	38	38	38	38
CGlobalAnx	Pearson Correlation	-.111	.121	.022	-.126

	Sig. (2-tailed)	.505	.469	.894	.449
	N	38	38	38	38
	Pearson Correlation	-.192	.070	.104	-.016
CGlobalAvoid	Sig. (2-tailed)	.247	.677	.535	.926
	N	38	38	38	38

Correlations

		TGlobalAnx	TGlobalAvoid	CGlobalAnx	CGlobalAvoid
	Pearson Correlation	-.282	-.321**	-.111	-.192
AnxietyChange	Sig. (2-tailed)	.086	.049	.505	.247
	N	38	38	38	38
	Pearson Correlation	-.396**	-.405	.121*	.070
DepressionChange	Sig. (2-tailed)	.014	.012	.469	.677
	N	38	38	38	38
	Pearson Correlation	-.520	-.506*	.022	.104**
ClientAllianceRaw	Sig. (2-tailed)	.001	.001	.894	.535
	N	38	38	38	38
	Pearson Correlation	-.666	-.455	-.126**	-.016
TherapistAllianceRaw	Sig. (2-tailed)	.000	.004	.449	.926
	N	38	38	38	38
	Pearson Correlation	1	.420*	-.082**	-.181**
TGlobalAnx	Sig. (2-tailed)		.009	.625	.276
	N	38	38	38	38
	Pearson Correlation	.420*	1*	-.116**	.019**
TGlobalAvoid	Sig. (2-tailed)	.009		.487	.909
	N	38	38	38	38
	Pearson Correlation	-.082	-.116	1	.819
CGlobalAnx	Sig. (2-tailed)	.625	.487		.000
	N	38	38	38	38
	Pearson Correlation	-.181	.019	.819	1
CGlobalAvoid	Sig. (2-tailed)	.276	.909	.000	
	N	38	38	38	38

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Regression

Descriptive Statistics

	Mean	Std. Deviation	N
DepressionChange	7.3684	4.52274	38
TherapistAllianceRaw	97.1842	13.82488	38
ClientAllianceRaw	96.9211	14.97634	38
c_att	1.8631	1.97442	38
t_att	.5468	1.59862	38
CxT	1.4901	3.87562	38

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	ClientAllianceRaw, TherapistAllianceRaw[b]	.	Enter
2	c_att, t_att[b]	.	Enter
3	CxT[b]	.	Enter

a. Dependent Variable: DepressionChange
b. All requested variables entered.

Model Summary[d]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics			
					R Square Change	F Change	df1	df2
1	.392[a]	.153	.105	4.27842	.153	3.173	2	35
2	.554[b]	.307	.223	3.98654	.154	3.656	2	33
3	.558[c]	.312	.204	4.03437	.005	.222	1	32

Model Summary[d]

Model	Change Statistics	Durbin-Watson

	Sig. F Change	
1	.054[a]	
2	.037[b]	
3	.641[c]	2.090

a. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw
b. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att
c. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att, CxT
d. Dependent Variable: DepressionChange

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	116.172	2	58.086	3.173	.054[b]
	Residual	640.670	35	18.305		
	Total	756.842	37			
2	Regression	232.391	4	58.098	3.656	.014[c]
	Residual	524.451	33	15.892		
	Total	756.842	37			
3	Regression	236.005	5	47.201	2.900	.029[d]
	Residual	520.837	32	16.276		
	Total	756.842	37			

a. Dependent Variable: DepressionChange
b. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw
c. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att
d. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att, CxT

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations
		B	Std. Error	Beta			Zero-order
1	(Constant)	-1.671	5.144		-.325	.747	
	TherapistAllianceRaw	-.062	.078	-.190	-.800	.429	.200
	ClientAllianceRaw	.156	.072	.516	2.167	.037	.372
2	(Constant)	-2.976	5.063		-.588	.561	
	TherapistAllianceRaw	-.077	.073	-.235	-1.058	.298	.200

	ClientAllianceRaw	.167	.069	.554	2.427	.021	.372
	c_att	.704	.347	.307	2.030	.051	.393
	t_att	.572	.439	.202	1.302	.202	.136
	(Constant)	-2.195	5.385		-.408	.686	
	TherapistAllianceRaw	-.080	.074	-.243	-1.077	.289	.200
3	ClientAllianceRaw	.163	.070	.538	2.310	.027	.372
	c_att	.609	.405	.266	1.507	.142	.393
	t_att	.391	.588	.138	.664	.511	.136
	CxT	.125	.265	.107	.471	.641	.345

Coefficients[a]

Model		Correlations	
		Partial	Part
	(Constant)		
1	TherapistAllianceRaw	-.134	-.124
	ClientAllianceRaw	.344	.337
	(Constant)		
	TherapistAllianceRaw	-.181	-.153
2	ClientAllianceRaw	.389	.352
	c_att	.333	.294
	t_att	.221	.189
	(Constant)		
	TherapistAllianceRaw	-.187	-.158
3	ClientAllianceRaw	.378	.339
	c_att	.257	.221
	t_att	.117	.097
	CxT	.083	.069

a. Dependent Variable: DepressionChange

Excluded Variables[a]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics Tolerance
	c_att	.350[b]	2.347	.025	.373	.961
1	t_att	.271[b]	1.710	.096	.281	.914
	CxT	.329[b]	2.208	.034	.354	.983

2	CxT	.107[c]	.471	.641	.083	.417

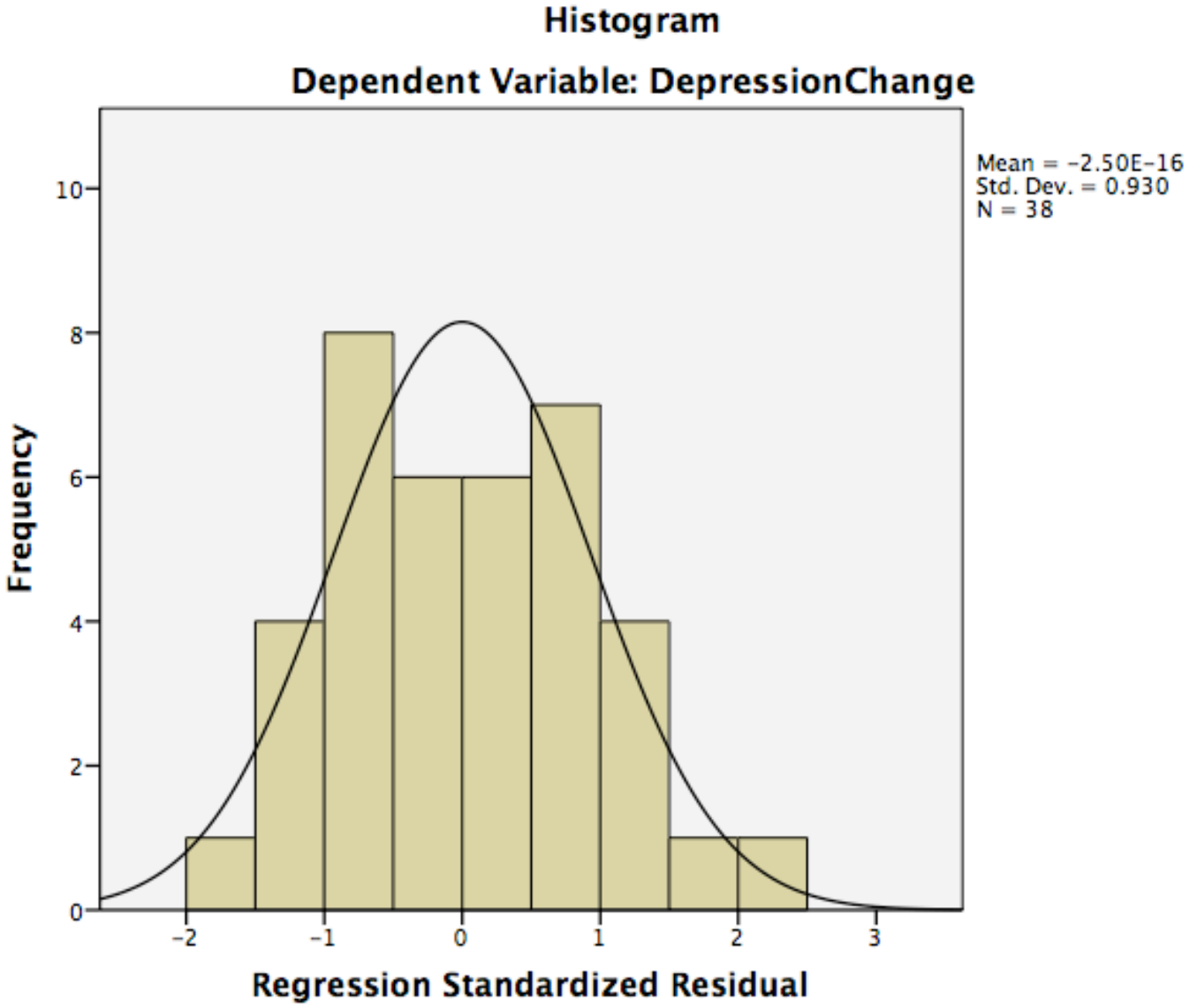
a. Dependent Variable: DepressionChange
b. Predictors in the Model: (Constant), ClientAllianceRaw, TherapistAllianceRaw
c. Predictors in the Model: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att

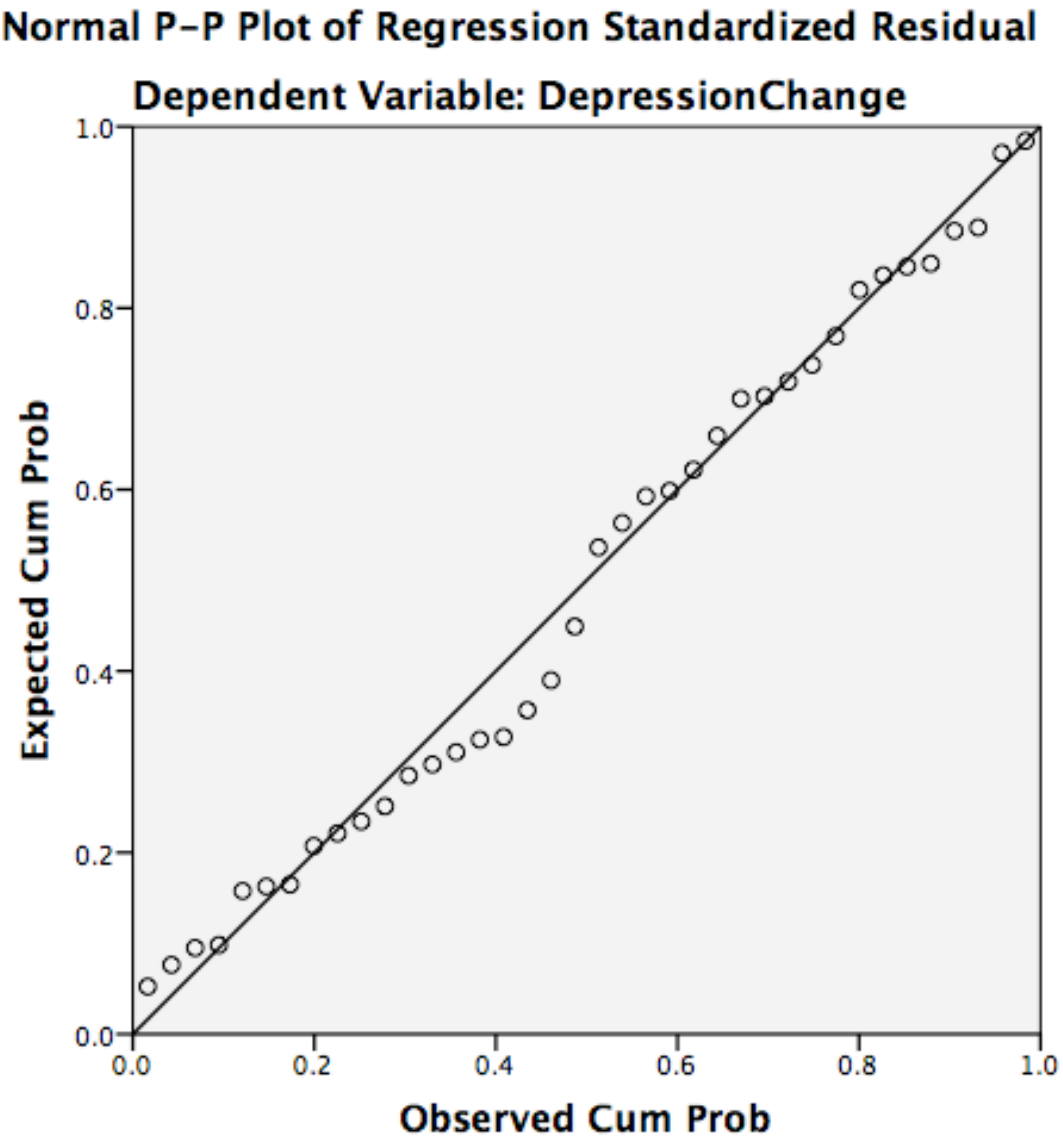
Residuals Statistics[a]

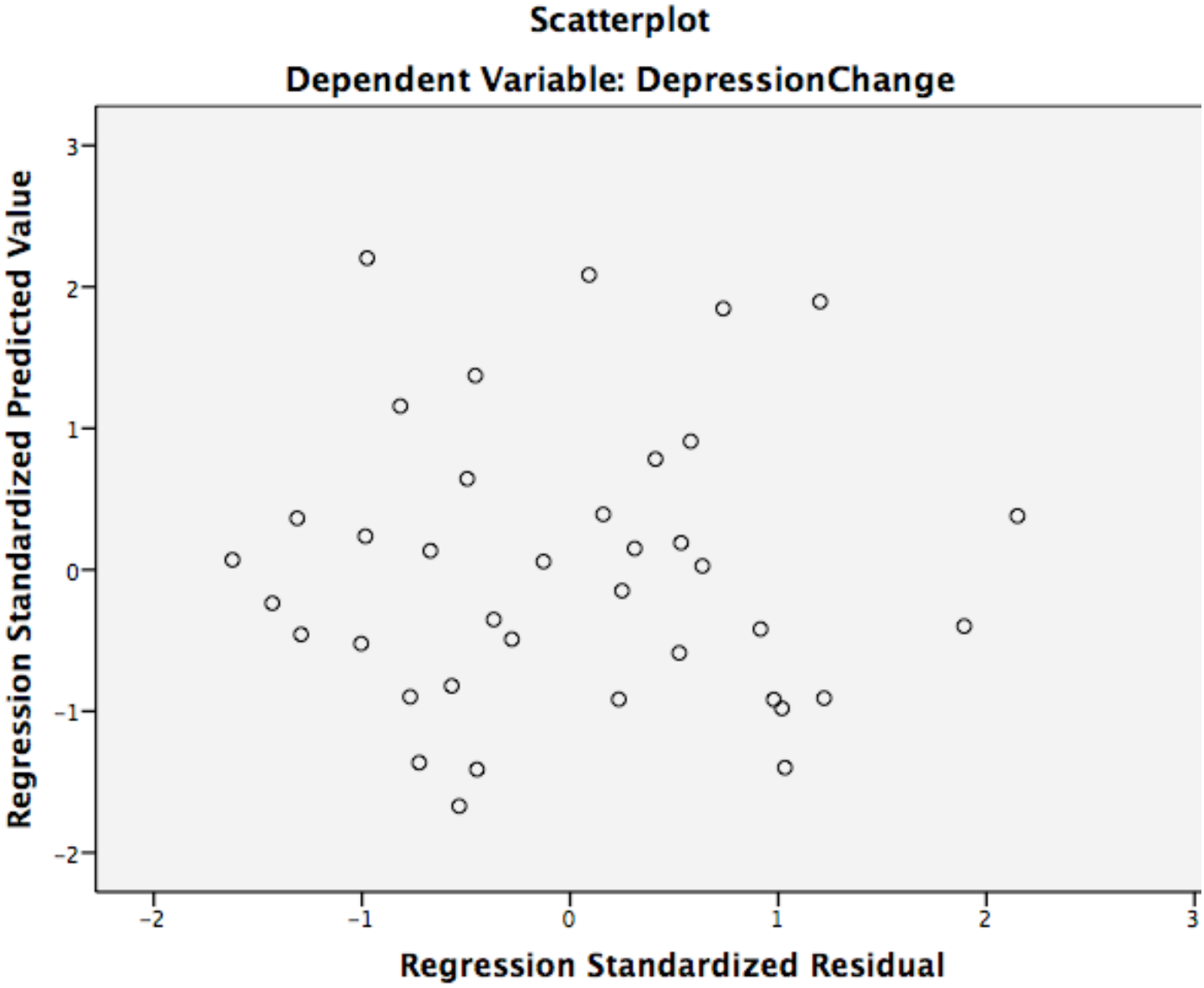
	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	3.1489	12.9334	7.3684	2.52557	38
Residual	-6.54506	8.67122	.00000	3.75189	38
Std. Predicted Value	-1.671	2.203	.000	1.000	38
Std. Residual	-1.622	2.149	.000	.930	38

a. Dependent Variable: DepressionChange

Charts


Histogram
Dependent Variable: DepressionChange
Mean = -2.50E-16
Std. Dev. = 0.930
N = 38
Frequency
0
2
4
6
8
10
-2
-1
0
1
2
3
Regression Standardized Residual


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: DepressionChange
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0



Frequencies

Statistics

comb			DepressionChange	AnxietyChange	TherapistAllianceRaw	ClientAllianceRaw
CSecure_TSecure	N	Valid	9	9	9	9

		Missing	0	0	0	0
	Mean		9.1111	11.2222	105.5556	102.5556
	Std. Deviation		6.09189	5.35672	5.02770	13.19196
CSecure_TPreoccupied	N	Valid	5	5	5	5
		Missing	0	0	0	0
	Mean		4.0000	3.4000	94.0000	96.4000
	Std. Deviation		3.67423	3.64692	11.04536	13.01153
CSecure_TDismissive	N	Valid	1	1	1	1
		Missing	0	0	0	0
	Mean		4.0000	3.0000	114.0000	109.0000
CSecure_TFearful	N	Valid	4	4	4	4
		Missing	0	0	0	0
	Mean		4.2500	4.0000	80.2500	76.0000
	Std. Deviation		2.75379	2.44949	8.57807	12.72792
CPreoccupied_TSecure	N	Valid	1	1	1	1
		Missing	0	0	0	0
	Mean		9.0000	10.0000	100.0000	114.0000
CPreoccupied_TPreoccupied	N	Valid	1	1	1	1
		Missing	0	0	0	0
	Mean		10.0000	15.0000	85.0000	92.0000
CDismissive_TSecure	N	Valid	2	2	2	2
		Missing	0	0	0	0
	Mean		8.5000	4.5000	95.0000	98.0000
	Std. Deviation		.70711	.70711	26.87006	22.62742
CFearful_TSecure	N	Valid	11	11	11	11
		Missing	0	0	0	0
	Mean		7.8182	5.5455	104.1818	101.7273
	Std. Deviation		3.68288	3.20511	11.39138	13.63885
CFearful_TPreoccupied	N	Valid	1	1	1	1
		Missing	0	0	0	0
	Mean		14.0000	10.0000	74.0000	88.0000
CFearful_TDismissive	N	Valid	2	2	2	2
		Missing	0	0	0	0

Statistics

comb			DepressionChange	AnxietyChange	TherapistAlliaceRaw	ClientAllianceRaw
CFearful_TDismissive	Mean		5.5000	5.5000	81.0000	83.5000
	Std. Deviation		6.36396	6.36396	1.41421	10.60660
CFearful_TFearful	N	Valid	1	1	1	1

	Missing	0	0	0	0
Mean		10.0000	11.0000	81.0000	89.0000

Regression

Descriptive Statistics

	Mean	Std. Deviation	N
AnxietyChange	6.9474	4.82083	38
TherapistAllianceRaw	97.1842	13.82488	38
ClientAllianceRaw	96.9211	14.97634	38
c_att	1.8631	1.97442	38
t_att	.5468	1.59862	38
CxT	1.4901	3.87562	38

Correlations

		AnxietyChange	TherapistAllianceRaw	ClientAllianceRaw	c_att	t_att
Pearson Correlation	AnxietyChange	1.000	.104	.313	.173	.080
	TherapistAllianceRaw	.104	1.000	.757	.190	-.208
	ClientAllianceRaw	.313	.757	1.000	.180	-.293
	c_att	.173	.190	.180	1.000	.153
	t_att	.080	-.208	-.293	.153	1.000
	CxT	.281	.129	.091	.518	.602
Sig. (1-tailed)	AnxietyChange	.	.266	.028	.150	.316
	TherapistAllianceRaw	.266	.	.000	.127	.105
	ClientAllianceRaw	.028	.000	.	.140	.037
	c_att	.150	.127	.140	.	.179
	t_att	.316	.105	.037	.179	
	CxT	.044	.221	.294	.000	.000
N	AnxietyChange	38	38	38	38	38
	TherapistAllianceRaw	38	38	38	38	38
	ClientAllianceRaw	38	38	38	38	38
	c_att	38	38	38	38	38
	t_att	38	38	38	38	38

CxT		38	38	38	38	38

Correlations

		CxT
Pearson Correlation	AnxietyChange	.281
	TherapistAllianceRaw	.129
	ClientAllianceRaw	.091
	c_att	.518
	t_att	.602
	CxT	1.000
Sig. (1-tailed)	AnxietyChange	.044
	TherapistAllianceRaw	.221
	ClientAllianceRaw	.294
	c_att	.000
	t_att	.000
	CxT	
N	AnxietyChange	38
	TherapistAllianceRaw	38
	ClientAllianceRaw	38
	c_att	38
	t_att	38
	CxT	38

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	ClientAllianceRaw, TherapistAllianceRaw[b]	.	Enter
2	c_att, t_att[b]	.	Enter
3	CxT[b]	.	Enter

a. Dependent Variable: AnxietyChange

b. All requested variables entered.

Model Summary[d]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics			
					R Square Change	F Change	df1	df2
1	.373[a]	.139	.090	4.59834	.139	2.834	2	35
2	.428[b]	.183	.084	4.61402	.044	.881	2	33
3	.463[c]	.214	.091	4.59554	.031	1.266	1	32

Model Summary[d]

Model	Change Statistics	Durbin-Watson
	Sig. F Change	
1	.072[a]	
2	.424[b]	
3	.269[c]	1.542

a. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw
b. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att
c. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att, CxT
d. Dependent Variable: AnxietyChange

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	119.831	2	59.915	2.834	.072[b]
	Residual	740.064	35	21.145		
	Total	859.895	37			
2	Regression	157.353	4	39.338	1.848	.143[c]
	Residual	702.542	33	21.289		
	Total	859.895	37			
3	Regression	184.088	5	36.818	1.743	.153[d]
	Residual	675.807	32	21.119		
	Total	859.895	37			

a. Dependent Variable: AnxietyChange
b. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw
c. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att
d. Predictors: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att, CxT

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations
		B	Std. Error	Beta			Zero-order
1	(Constant)	.366	5.529		.066	.948	
	TherapistAllianceRaw	-.108	.084	-.311	-1.295	.204	.104
	ClientAllianceRaw	.177	.077	.548	2.286	.028	.313
2	(Constant)	-1.174	5.859		-.200	.842	
	TherapistAllianceRaw	-.115	.084	-.329	-1.362	.182	.104
	ClientAllianceRaw	.191	.080	.594	2.398	.022	.313
	c_att	.249	.402	.102	.621	.539	.173
	t_att	.514	.509	.170	1.010	.320	.080
3	(Constant)	.949	6.134		.155	.878	
	TherapistAllianceRaw	-.122	.084	-.349	-1.445	.158	.104
	ClientAllianceRaw	.179	.080	.555	2.228	.033	.313
	c_att	-.008	.461	-.003	-.018	.986	.173
	t_att	.020	.670	.007	.031	.976	.080
	CxT	.340	.302	.273	1.125	.269	.281

Coefficients[a]

Model		Correlations	
		Partial	Part
1	(Constant)		
	TherapistAllianceRaw	-.214	-.203
	ClientAllianceRaw	.360	.358
2	(Constant)		
	TherapistAllianceRaw	-.231	-.214
	ClientAllianceRaw	.385	.377
	c_att	.107	.098
	t_att	.173	.159
3	(Constant)		
	TherapistAllianceRaw	-.248	-.227
	ClientAllianceRaw	.366	.349
	c_att	-.003	-.003
	t_att	.005	.005
	CxT	.195	.176

a. Dependent Variable: AnxietyChange

Excluded Variables[a]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics Tolerance
1	c_att	.138[b]	.861	.395	.146	.961
	t_att	.193[b]	1.184	.244	.199	.914
	CxT	.276[b]	1.798	.081	.295	.983
2	CxT	.273[c]	1.125	.269	.195	.417

a. Dependent Variable: AnxietyChange

b. Predictors in the Model: (Constant), ClientAllianceRaw, TherapistAllianceRaw

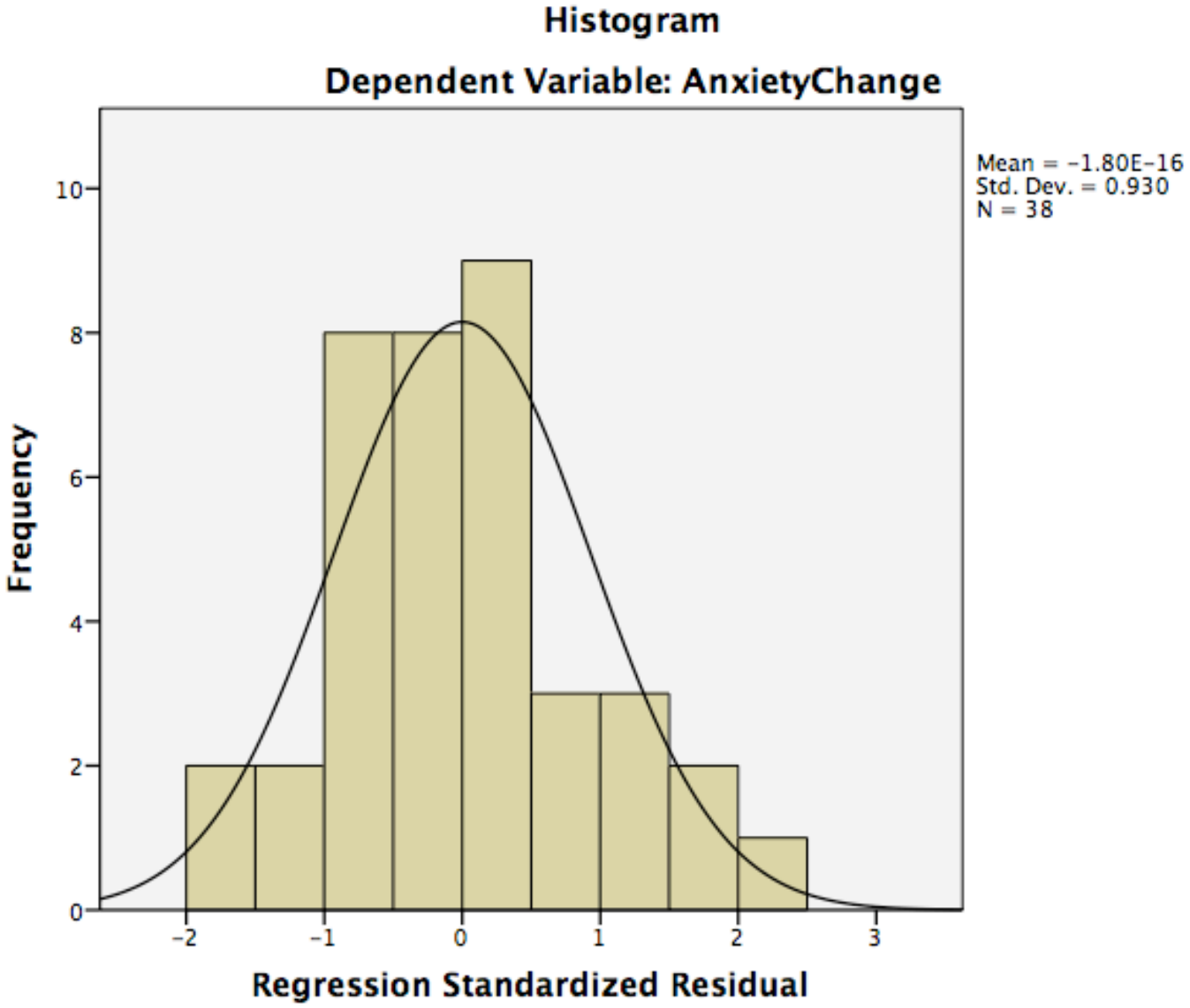
c. Predictors in the Model: (Constant), ClientAllianceRaw, TherapistAllianceRaw, c_att, t_att

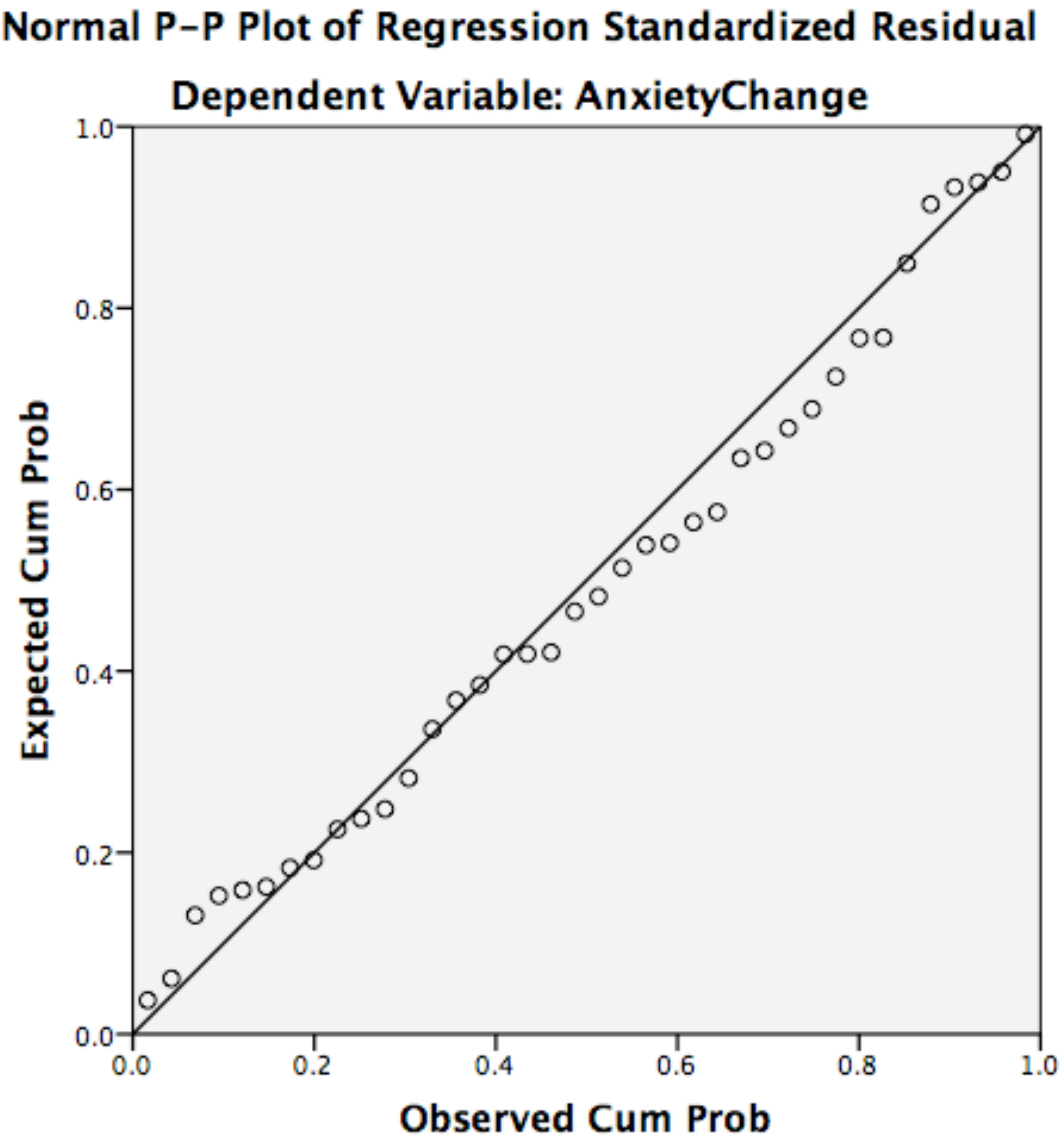
Residuals Statistics[a]

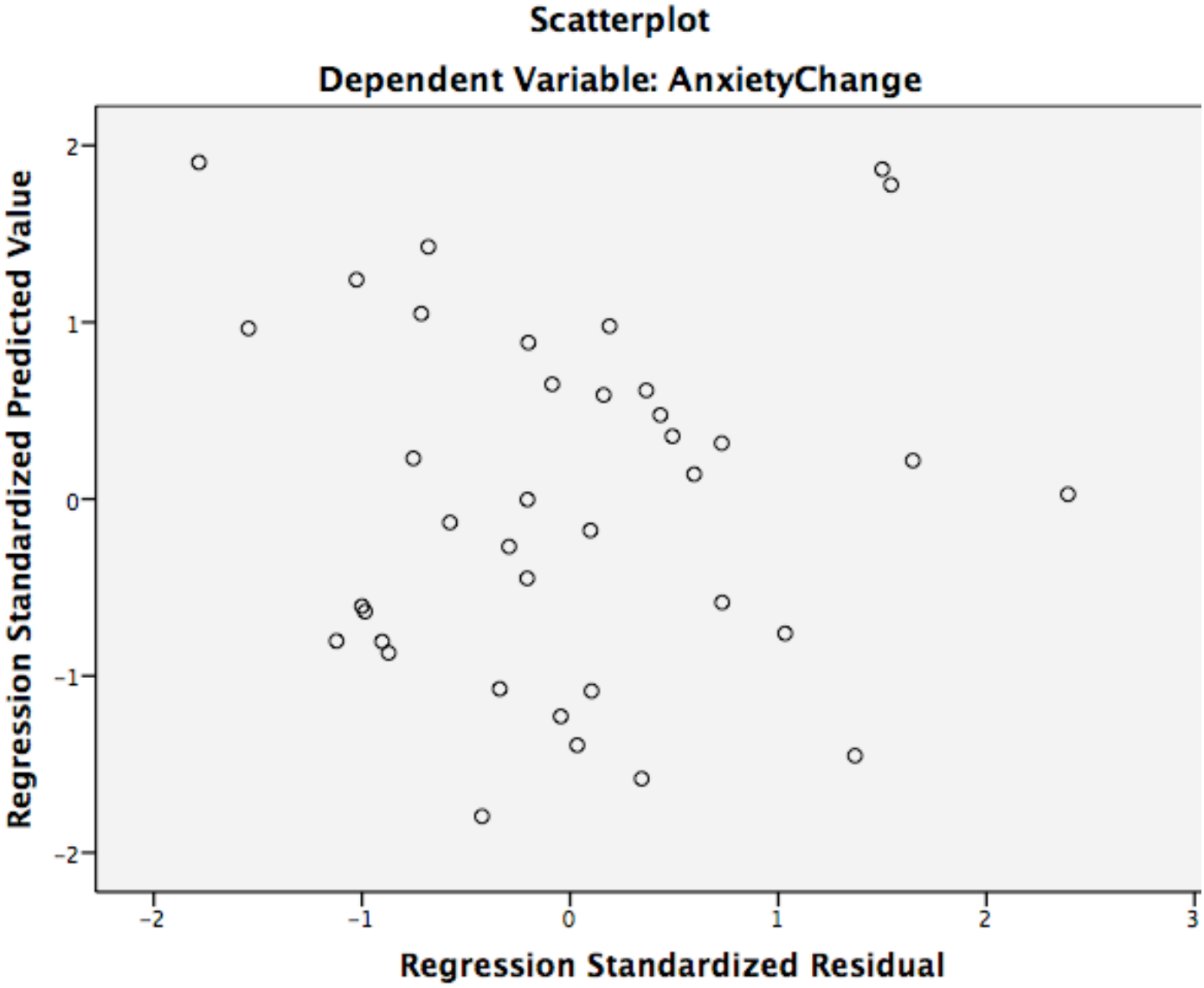
	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	2.9446	11.1942	6.9474	2.23055	38
Residual	-8.19417	10.99274	.00000	4.27376	38
Std. Predicted Value	-1.795	1.904	.000	1.000	38
Std. Residual	-1.783	2.392	.000	.930	38

a. Dependent Variable: AnxietyChange

Charts


Histogram
Dependent Variable: AnxietyChange
Mean = -1.80E-16
Std. Dev. = 0.930
N = 38
Frequency
0
2
4
6
8
10
-2
-1
0
1
2
3
Regression Standardized Residual


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: AnxietyChange
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0


Scatterplot
Dependent Variable: AnxietyChange
Regression Standardized Predicted Value
Regression Standardized Residual
2
1
0
-1
-2
-2
-1
0
1
2
3

Appendix 21

SPSS SYNTAX

Attachment

Attachment recode

```
RECODE Tecr1_m Tecr2_m Tecr3_m Tecr4_m Tecr1_fa Tecr2_fa Tecr3_fa Tecr4_fa Tecr1_p
Tecr2_p Tecr3_p
   Tecr4_p Tecr1_fr Tecr2_fr Tecr3_fr Tecr4_fr Cecr1_m Cecr2_m Cecr3_m Cecr4_m Cecr1_fa
Cecr2_fa
   Cecr3_fa Cecr4_fa Cecr1_p Cecr2_p Cecr3_p Cecr4_p Cecr1_fr Cecr2_fr Cecr3_fr Cecr4_fr
(7=1) (6=2)
   (5=3) (4=4) (3=5) (2=6) (1=7) (MISSING=Copy) INTO Tecr1_mr Tecr2_mr Tecr3_mr
Tecr4_mr Tecr1_far
   Tecr2_far Tecr3_far Tecr4_far Tecr1_pr Tecr2_pr Tecr3_pr Tecr4_pr Tecr1_frr Tecr2_frr
Tecr3_frr
   Tecr4_frr Cecr1_mr Cecr2_mr Cecr3_mr Cecr4_mr Cecr1_far Cecr2_far Cecr3_far Cecr4_far
Cecr1_pr
   Cecr2_pr Cecr3_pr Cecr4_pr Cecr1_frr Cecr2_frr Cecr3_frr Cecr4_frr.
EXECUTE.


DATASET ACTIVATE DataSet1.
COMPUTE AnxietyM=SUM(Tecr5_m,Tecr6_m,Tecr1_mr,Tecr2_mr,Tecr3_mr,Tecr4_mr)/6.
EXECUTE.

COMPUTE TAnxietyF=SUM(Tecr5_fa,Tecr6_fa,Tecr1_far,Tecr2_far,Tecr3_far,Tecr4_far)/6.
EXECUTE.

COMPUTE TAnxietyP=SUM(Tecr5_p,Tecr6_p,Tecr1_pr,Tecr2_pr,Tecr3_pr,Tecr4_pr)/6.
EXECUTE.

COMPUTE TAnxietyFr=SUM(Tecr5_fr,Tecr6_fr,Tecr1_frr,Tecr2_frr,Tecr3_frr,Tecr4_frr)/6.
EXECUTE.

COMPUTE TAvoidanceM=SUM(Tecr7_m,Tecr8_m,Tecr9_m)/3.
EXECUTE.

COMPUTE TAvoidanceFa=SUM(Tecr7_fa,Tecr8_fa,Tecr9_fa)/3.
EXECUTE.

COMPUTE TAvoidanceP=SUM(Tecr7_p,Tecr8_p,Tecr9_p)/3.
EXECUTE.
```

```
COMPUTE TAvoidancefr=SUM(Tecr7_fr,Tecr8_fr,Tecr9_fr)/3.
EXECUTE.

COMPUTE CAnxietyM=SUM(Cecr5_m,Cecr6_m,Cecr1_mr,Cecr2_mr,Cecr3_mr,Cecr4_mr)/6.
EXECUTE.

COMPUTE CAnxietyFa=SUM(Cecr5_fa,Cecr6_fa,Cecr1_far,Cecr2_far,Cecr3_far,Cecr4_far)/6.
EXECUTE.

COMPUTE CAnxietyP=SUM(Cecr5_p,Cecr6_p,Cecr1_pr,Cecr2_pr,Cecr3_pr,Cecr4_pr)/6.
EXECUTE.

COMPUTE CAnxietyFr=SUM(Cecr5_fr,Cecr6_fr,Cecr1_frr,Cecr2_frr,Cecr3_frr,Cecr4_frr)/6.
EXECUTE.

COMPUTE CAvoidanceM=SUM(Cecr7_m,Cecr8_m,Cecr9_m)/3.
EXECUTE.

COMPUTE CAvoidanceFa=SUM(Cecr7_fa,Cecr8_fa,Cecr9_fa)/3.
EXECUTE.

COMPUTE CAvoidanceP=SUM(Cecr7_p,Cecr8_p,Cecr9_p)/3.
EXECUTE.

COMPUTE CAvoidanceFr=SUM(Cecr7_fr,Cecr8_fr,Cecr9_fr)/3.
EXECUTE.

COMPUTE TGlobalAnx=SUM(TAnxietyM,TAnxietyFa,TAnxietyP,TAnxietyFr)/4.
EXECUTE.

COMPUTE TGlobalAvoid=SUM(TAvoidanceM,TAvoidanceFa,TAvoidanceP,TAvoidancefr)/4.
EXECUTE.

COMPUTE CGlobalAnx=SUM(CAnxietyM,CAnxietyFa,CAnxietyP,CAnxietyFr)/4.
EXECUTE.

COMPUTE
CGlobalAvoid=SUM(CAvoidanceM,CAvoidanceFa,CAvoidanceP,CAvoidanceFr)/4.
EXECUTE.


IF (CGlobalAvoid<3.5 and CGlobalAnx<3.5)ecr=1.
IF (CGlobalAvoid<3.5 and CGlobalAnx>3.5)ecr=2.
IF (CGlobalAvoid>3.5 and CGlobalAnx<3.5)ecr=3.
IF (CGlobalAvoid>3.5 and CGlobalAnx>3.5)ecr=4.
```

IF (CGlobalAvoid=3.5 and CGlobalAnx<3.5)ecr=1.
IF (CGlobalAvoid=3.5 and CGlobalAnx>3.5)ecr=2.
IF (CGlobalAvoid=3.5 and CGlobalAnx<3.5)ecr=3.
IF (CGlobalAvoid=3.5 and CGlobalAnx>3.5)ecr=4.

IF (CGlobalAvoid<3.5 and CGlobalAnx=3.5)ecr=1.
IF (CGlobalAvoid<3.5 and CGlobalAnx=3.5)ecr=2.
IF (CGlobalAvoid>3.5 and CGlobalAnx=3.5)ecr=3.
IF (CGlobalAvoid>3.5 and CGlobalAnx=3.5)ecr=4.

IF (TGlobalAvoid<3.5 and TGlobalAnx<3.5)ecr=1.
IF (TGlobalAvoid<3.5 and TGlobalAnx>3.5)ecr=2.
IF (TGlobalAvoid>3.5 and TGlobalAnx<3.5)ecr=3.
IF (TGlobalAvoid>3.5 and TGlobalAnx>3.5)ecr=4.

IF (TGlobalAvoid=3.5 and TGlobalAnx<3.5)ecr=1.
IF (TGlobalAvoid=3.5 and TGlobalAnx>3.5)ecr=2.
IF (TGlobalAvoid=3.5 and TGlobalAnx<3.5)ecr=3.
IF (TGlobalAvoid=3.5 and TGlobalAnx>3.5)ecr=4.

IF (TGlobalAvoid<3.5 and TGlobalAnx=3.5)ecr=1.
IF (TGlobalAvoid<3.5 and TGlobalAnx=3.5)ecr=2.
IF (TGlobalAvoid>3.5 and TGlobalAnx=3.5)ecr=3.
IF (TGlobalAvoid>3.5 and TGlobalAnx=3.5)ecr=4.

1=secure
2=preoccupied
3=Dismissing
4= fearful

IF (DepressionPre<4)predepdiag=1
IF (DepressionPre>4.1 and DepressionPre<9)predepdiag=2
IF (DepressionPre>9.1 and DepressionPre<14)predepdiag=3
IF (DepressionPre>14.1 and DepressionPre<19)predepdiag=4
IF (DepressionPre>19.1 and DepressionPre<27)predepdiag=5

IF (DepressionPost<4)postdepdiag=1
IF (DepressionPost>4.1 and DepressionPost<9)postdepdiag=2
IF (DepressionPost>9.1 and DepressionPost<14)postdepdiag=3
IF (DepressionPost>14.1 and DepressionPost<19)postdepdiag=4
IF (DepressionPost>19.1 and DepressionPost<27)postdepdiag=5

IF (AnxietyPre<4)preanxdiag=1

```
IF (AnxietyPre>4.1 and AnxietyPre<9)preanxdiag=2
IF (AnxietyPre>9.1 and AnxietyPre<14)preanxdiag=3
IF (AnxietyPre>14.1 and AnxietyPre<19)preanxdiag=4
IF (AnxietyPre>19.1 and AnxietyPre<21)preanxdiag=5

IF (AnxietyPost<4)postanxdiag=1
IF (AnxietyPost>4.1 and AnxietyPost<9)postanxdiag=2
IF (AnxietyPost>9.1 and AnxietyPost<14)postanxdiag=3
IF (AnxietyPost>14.1 and AnxietyPost<19)postanxdiag=4
IF (AnxietyPost>19.1 and AnxietyPost<21)postanxdiag=5
```

Thrapeutic Alliance Recode

```
DATASET ACTIVATE DataSet1.
RECODE Thaq4 Thaq8 Thaq11 Thaq16 Thaq19 Chaq4 Chaq8 Chaq11 Chaq16 Chaq19 (6=1)
(5=2) (4=3) (3=4)
   (2=5) (1=6) (MISSING=Copy) INTO Thaq4r Thaq8r Thaq11r Thaq16r Thaq19r Chaq4r
Chaq8r Chaq11r Chaq16r
   Chaq19r.
EXECUTE.
```

Compute Variables

```
COMPUTE
DepressionPre=SUM(phq1_1,phq2_1,phq3_1,phq4_1,phq5_1,phq6_1,phq7_1,phq8_1,phq9_1).
EXECUTE.

COMPUTE AnxietyPre=SUM(gad1_1,gad2_1,gad3_1,gad4_1,gad5_1,gad6_1,gad7_1).
EXECUTE.

COMPUTE AnxietyPost=SUM(gad1_2,gad2_2,gad3_2,gad4_2,gad5_2,gad6_2,gad7_2).
EXECUTE.

COMPUTE
TherapistAlliance=SUM(Thaq1,Thaq2,Thaq3,Thaq5,Thaq6,Thaq7,Thaq9,Thaq10,Thaq12,Thaq
13,Thaq14,
   Thaq15,Thaq17,Thaq18,Thaq4r,Thaq8r,Thaq11r,Thaq16r,Thaq19r).
EXECUTE.


COMPUTE
TAllianceMean=SUM(Thaq1,Thaq2,Thaq3,Thaq5,Thaq6,Thaq7,Thaq9,Thaq10,Thaq12,Thaq13,
Thaq14,
   Thaq15,Thaq17,Thaq18,Thaq4r,Thaq8r,Thaq11r,Thaq16r,Thaq19r)/19.
EXECUTE.
```

```
COMPUTE
CAllianceMean=SUM(Chaq1,Chaq2,Chaq3,Chaq5,Chaq6,Chaq7,Chaq9,Chaq10,Chaq12,Chaq1
3,Chaq14,
    Chaq15,Chaq17,Chaq18,Chaq4r,Chaq8r,Chaq11r,Chaq16r,Chaq19r)/19.
EXECUTE.

COMPUTE CAliMeanDevTotal=Sum(CAllianceMean -.79) * 19 .
EXECUTE.

COMPUTE TAliMeanDevTotal=Sum(TAllianceMean -.73) * 19 .
EXECUTE.
```